Empathetic Consultation Skills in Undergraduate Medical Education: A Qualitative Approach.

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In memory of Uncle Brian and Billy.

Abstract

The practice of medicine involves caring for patients on many levels, which range from the scientific inquiry and administration of treatment, to the interaction and communication that occurs in consultations. The requisite for care in medical practice has been widely documented, and the role of empathy is acknowledged and recognised in this process; however, it is often difficult to express in a communicative framework. Previous research has tended to focus on measuring empathy, with little consideration given to how empathy is realised within interaction. Where attempts have been made to document these communicative acts, deductive approaches have generally been prevalent.

This thesis reports on an inductive approach used to explore how empathy is perceived to be expressed in undergraduate medical education. The methodology used consisted of two phases. The first phase is described as a quasi-grounded theory approach, which utilised member coding in the categorisation of empathetic strategies. The second phase adopted tools from the field of sociolinguistics, and examined the categories derived from the first phase to build toward a paradigm of interactional empathy in medical consultations.

Three primary findings arose from the data. Two of these were sociolinguistic in nature, and related to the *elicitation of patient experiences*, and the *initiation of empathetic opportunities* in the consultation. The other main finding concerned the *administrative aspect of empathy*, and how this can be vital to the establishment and preservation of an empathetic ethos throughout the healthcare process. The results augment and support the current methods of teaching at the University of East Anglia via the Calgary-Cambridge guide, and reflect empathy as an integrative practice rather than an individual skill in medical communication.

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Compact disc containing all transcripts of simulated consultations quoted in the main text, and the transcript of the interview conducted with the focus group.

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CHAPTER ONE: INTRODUCTION

1.0. INTRODUCTION

This chapter introduces the thesis as a whole. It begins with a statement of the problems which occur when studying empathy. It then discusses the purpose of the study, and the area of empathy this research addresses. The aims and objectives are then listed and the methodology used to address these questions is described. Finally, the chapter concludes with an explanation of the scope of the thesis, with the contents of each chapter being briefly summarised.

1.1. STATEMENT OF PROBLEM

The practice of medicine involves caring for patients on many levels, which range from the scientific inquiry and administration of treatment, to the interaction and communication that occurs in consultations. It has been asserted that communication skills are fundamental to the practice of medicine (Silverman et al., 2004), with the General Medical Council (GMC) claiming that 'good communication will enable [a doctor] to work in partnership with [their] patients to address their individual needs' (GMC, 2006: 15). Recent research evidence and evolving cultural expectations have led the GMC to call for undergraduate medical education to introduce communication skills training; however, the definition of good communication skills is ill-defined in terms of its theoretical backing. One of the areas in which this backing is particularly sparse is with regard to emotional or empathetic aspects of communication. The requisite for care in medical practice has been widely documented (Peabody, 1927, Osler, 1932), and the role of empathy is acknowledged and recognised in this process (Frankel, 2009, Spiro et al., 1996); however, it is often difficult to express within a communicative framework. This becomes especially pertinent in medical consutlations, as a patient has to feel that their perspective on the problems that they are encountering is being understood. However, training

doctors to recognise and express empathy where it is required is a complex and multifaceted task. A person may be able to empathise with another, but may not be able to express this in communication, meaning the recipient of the empathy might not feel understood. This highlights the importance of the communicative aspect of empathy: a doctor may feel empathy at a cognitive level, but if they cannot express this to the patient, then the process is incomplete and less useful to the patient. It is the expression of empathy which is the key focus of this research.

It is important to highlight that this thesis is ***not*** a study of the concept of empathy, but a study of how empathy is ***perceived*** to be expressed in medicine; particularly medical education and those involved in the consultation skills training (the tutor, medical students, simulated patients and end users/patients). There is fierce debate and contrasting opinions about what empathy is and whether it can be taught (Davis, 1990, Spiro, 1992). To an extent, the initial inductive approach taken in this thesis makes the philosophical question 'what is empathy' a secondary consideration. The thesis is not about trying to measure empathy, but it is concerned with exploring how empathy is perceived to be expressed within a communicative framework. Hence it is about perceptions of empathy, rather than empathy itself. More specifically, the aims of the thesis are as follows:

- To explore how empathy is perceived to be expressed by people involved in undergraduate consultation skills training and assessment at the University of East Anglia.
- To build a framework of empathetic expressions through the examination of associated behaviours (henceforth referred to as 'behavioural correlates') in simulated consultations.
- To explicate this framework and examine the communicative features of interaction which co-occur with perceived expressions of empathy.

1.2. AUTHOR'S BACKGROUND AND CHRONOLOGY TO STUDY

The inspiration for this study grew out of a need for augmentation of the empathetic content provided as a part of the MB/BS degree at UEA; specifically how empathy is

expressed in interaction. After discussing the topic of empathy with a number of the medical students, it soon became apparent that one of the difficulties they had with the empathetic aspect of the consultation was not necessarily being trained to *feel* empathy, but that they were unsure of how to express it. During my first week at UEA, one second year medical student remarked: 'I'm feeling empathy towards the patient – I can understand it must be hard for them – but I just don't know how to show it'. Hence, the aim of this thesis became more focused on training medical students how to express empathy to a patient, rather than learning how to feel empathy. In this sense, the thesis makes the assumption that the medical students recruited can and do feel empathy, but it is the interactional realisation of this which is problematic to them. There are measures in place at UEA to select only the most suitable candidates, with capacity for empathy being a characteristic considered in the recruitment process, although it was anticipated that the findings from this thesis could also assist with this recruitment, as well as training, of medical students (although this is very much a secondary aim, and likely a task of further research).

The focus on interaction grew out of my background in linguistics. I completed a BA in English Language with Linguistics at the University of Kent, and decided to pursue the linguistic element further; particularly aspects of sociolinguistics, such as pragmatics and Conversation Analysis. I completed a research MA in Applied Linguistics at the University of Reading, and was then inspired by the prospect of transferring these skills to the investigation of the medical world, which was offered by UEA. Moreover, during the end of my third year at Kent, and between my MA and the start of this thesis, I was asked to teach English to students from universities in Hong Kong and Japan during the summer months at the University of Kent. This initiated my interest in the pedagogical aspect of language and interaction, which I carried through to UEA. Once at UEA, I was offered the opportunity to begin teaching on the consultation skills module of the MB/BS degree, and have now been doing so since 2009. Thus, this is where the interest in both the interactional and pedagogical elements of this thesis developed from.

1.3. PURPOSE OF STUDY

The purpose of this study was to help improve two main areas of the Medical Bachelor/Bachelor of Surgery (*MB/BS)* programme at the UEA, although the findings are transferrable to other medical training programmes in both undergraduate and postgraduate health and medical education. The first of these was how the programme could be augmented with knowledge about how empathy is perceived to be expressed from different perspectives. This involved aspects of language, gesture and non-verbal behaviour, although the primary focus of this thesis was concerned with the language used in expressing empathy (gesture and non-verbal behaviour are discussed, but to a lesser extent). It has been argued that empathy may not be a teachable phenomenon (Davis, 1990), however, language is, and people can at least be made aware of how to verbalise and gesticulate their empathy to show others that they are being understood, thus helping with the medical students' consultation skills training. In addition to this, the research was also applicable to the MB/BS recruitment, with a focus on recognising how empathy is expressed by potential students during interview, thus giving the interviewers a sound idea of the features they are looking for students to display. Ultimately, the overarching aim was to help inform the recruitment process, and, more importantly, help ensure that the candidates awarded places were then given the best possible training with regard to the empathetic content of a consultation. This may lead to better doctors and combat some of the problems that are frequently encountered in medical communication.

1.4. NATURE OF STUDY

Empathy is a complex and largely subjective concept; however, the majority of studies that have been conducted adopt a quantitative approach, measuring empathy numerically (Hemmerdinger et al., 2007, Satterfield and Ellen, 2007, Pedersen, 2009, Neumann et al., 2011). It could be argued that assigning numbers to what is essentially an abstract noun is not the best encompassing method of assessment. Reidar Pedersen notes that 'qualitative approaches are rarely used' when studying empathy (Pedersen, 2009: 307), and he conducted a critical review of empathy in

medicine. The results indicated that from 206 studies, only 33 used qualitative data when measuring empathy, and only 24 of these studied empathy implicitly. Moreover, the majority of these qualitative studies focused around using interviews and questionnaires, largely ignoring the conversational structure and language used in the expression of empathy. Some papers which focused on communication in medical care did discuss empathy as a strategy for dealing with patients; however, this was usually as an afterthought, and not the primary focus of the paper (Pedersen, 2009). A minority of other papers focused on how empathy was expressed (Wynn, 2005, Martinovski et al., 2007, Cordella and Musgrave, 2009), but all of these papers had aspects which had the potential for further development, and these are discussed in more depth in chapter four.

To summarise, this project aimed to expand the level of research which already existed by adopting a qualitative approach. The methodology itself was split into two main phases. The first phase could be described as a quasi-grounded theory approach. Whereas previous papers had made assumptions about what empathy is, this inductive approach allowed for a much more open, unbiased and, arguably, accurate account of empathetic expression. The second phase used a qualitative approach that was rooted in the field of applied linguistics. Within this discipline, the project built on numerous linguistic approaches and theories, using tools from the fields of conversation analysis and pragmatics to analyse the behavioural correlates of empathy which arose from the inductive approach, and built toward an interactional theory of empathy, which may be utilised in medical education.

1.5. SCOPE OF STUDY

The thesis is divided into four sections, which span eleven chapters. Section One consists of Chapters Two, Three and Four. Chapter Two introduces the background to the research. Definitions of empathy which have previously been coined in the literature are discussed, and the differences between empathy and sympathy are considered. The chapter continues to highlight why empathy is needed in medical education and the medical profession, with factors such as the accuracy of diagnosis, the patient's adherence to treatment, physician well-being, the avoidance of

malpractice lawsuits, and increases in patient satisfaction all being reasons for the necessity of empathy. Finally, the chapter concludes with a description of how consultation skills are currently taught, with a particular focus on whether empathy *can* actually be taught, and how the topic of consultation skills as a whole is currently dealt with at the UEA. Chapter Three is a review of the literature pertaining to empathy in medicine. The chapter begins with an overview of the quantitative research that has been done in the field, with the key findings from these papers being that gender affects empathy levels in doctors and medical students, empathy is a teachable phenomenon, and that levels of empathy decline during medical school. It then proceeds to explore some of the qualitative research which has been conducted in the field. Chapter Four describes the protocol for a structured literature review of qualitative research papers, which examine how empathy is expressed in medical practice and education. The papers found through this search strategy are then appraised in order to elicit the gaps in the literature, which form the basis for the aims and objectives of the thesis.

Section Two details the approach taken to address the aims and objectives, and consists of Chapters Five and Six, which comprise the methodology and methods used in this research. Chapter Five begins by setting out the research questions which were acquired from the structured review of the literature. A conceptual framework for tackling these questions is then discussed, with the study broadly adopting a social constructivist stance and interpretivist paradigm. This leads to a description of the methodology in Chapter Six, which draws on two main qualitative approaches: grounded theory and sociolinguistics. Implications of using a quasi-grounded theory methodology are detailed, with issues surrounding the use of literature, theoretical sampling and coding being highlighted. The chapter then discusses two main areas of what can broadly be termed sociolinguistics: pragmatics and conversation analysis, with an emphasis on sequential analysis, politeness principles and cooperation. The second part of Chapter Six explains the methods used in collecting and analysing the data, with information about participants, materials, and the method itself, and also a description of the ethical considerations and trustworthiness of the project being detailed.

Section Three involves a description of the findings from the research, and the subsequent analysis of these findings. Chapter Seven introduces the findings from the project through a thematic analysis, and begins to build a framework pertaining to factors influencing how empathy is perceived to be expressed. Chapters Eight and Nine draw on the findings from Chapter Seven, and explicate the analysis further. Specifically, Chapter Eight deals with eliciting patient experiences, whereas Chapter Nine is concerned with the initiation of empathetic opportunities within the consultation.

Section Four contains Chapter Ten and Eleven, which function as the discussion and conclusion to the thesis. Chapter Ten details the principle findings from the research, with the final framework being brought together. It then appraises the methods used in this study, describes the limitations, and draws comparison with previous work. Chapter Eleven then proceeds to provide details about the clinical and educational implications from the research, and the chapter concludes with suggestions for furthering the research. The Appendix follows this chapter, and contains the glossary of abbreviations, a summary of the transcription conventions, some examples of the transcripts, and the forms used in the project's recruitment strategy. The transcripts of all the data, including the simulated consultations and focus group are also included on a compact disc.

SECTION ONE

CHAPTER TWO: BACKGROUND

2.0. INTRODUCTION

This chapter begins with some of the seminal definitions of empathy found in the literature. More specifically, the link between empathy and sympathy is discussed, as well as the neuroscience of empathy: how it works at a cognitive level within the brain. The chapter then proceeds to discuss the advantages of empathy in medical practice, with accuracy of diagnosis, adherence to treatment, patient satisfaction and avoidance of malpractice suits all being noted as outcomes of using empathy in medicine. The final part of the chapter details the role that empathy plays within the current teaching on medical degrees, with specific examples being drawn from the programme at the UEA.

2.1. THE CONCEPT OF EMPATHY

2.1.1. Definitions of Empathy

Empathy is widely spoken about in terms of 'putting yourself in someone else's shoes', and while this analogy touches upon what empathy is, the concept itself is far more complex and arduous to define. The Oxford English Dictionary describes empathy as being 'the power of projecting one's personality into (and so fully comprehending) the object of contemplation' (OED, 2009), again suggesting a transference of perspective from one person to another. It also notes that empathy is an abstract noun: it cannot be touched, seen, smelt or heard, yet we accept its existence, and agree upon many of the main features involved in the concept. One of the seminal definitions of empathy comes from the field of psychotherapy, where Carl Rogers defined the concept as 'to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if'

condition' (Rogers, 1959: 210). However, no single definition of empathy is widely agreed upon. Daniel Batson (2009) highlights this, listing what he terms 'eight related but distinct phenomenon' in relation to empathy, which demonstrate the array of opinion pertaining to definitions of empathy:

- Knowing another person's internal state, including his or her thoughts and feelings.
- Adopting the posture or matching the neural responses of another.
- Coming to feel as another person feels.
- Intuiting or projecting oneself into another's situation.
- Imagining how another is thinking or feeling.
- Imagining how one would think and feel in the other's place.
- Feeling distress at witnessing another person's suffering.
- Feeling for another person who is suffering (Batson, 2009: 4-8).

The term 'empathy' has its etymological roots stemming from the Greek 'em' meaning 'in', and 'pathos' referring to a sense of 'feeling sorrow or suffering'. From this, the term 'Einfühlung' was originally coined in the German language to refer to projection of human feeling into works of art and nature, and the concept was translated and introduced into the English language as 'empathy' in 1909 by Edward Titchener. This interpretation of empathy was expanded upon by Theodor Lipps to incorporate empathy as being core to social and human sciences (Karsten, 2013) . As previously alluded to, the English usage of the word 'empathy' is fiercely debated; however, generally in the literature two main types of empathy are defined: cognitive and emotional (Duan and Hill, 1996, Davis, 1994).

Cognitive empathy (also referred to in the literature as *perspective taking*, and *role taking*) generally refers to taking the perspective of another person; being able to understand how another person thinks or feels at a given moment in time. It has been pointed out that while 'this makes for good debaters, sales people and negotiators [...] people who have strengths in cognitive empathy alone can lack compassion – they get how you see it, but don't care about you' (Goleman, 2009). In contrast to this, emotional empathy (also referred to in the literature as *sympathy*, *affective*

empathy and *emotional responsiveness*) involves two subcategories consisting of parallel and reactive empathy. Parallel empathy pertains to emotional responses to another person which 'parallel' their thoughts and feelings at the time, whereas reactive empathy involves reacting directly to the emotional responses of the other person. Stephan and Finlay (Stephan and Finlay, 1999) provide a clear example of the distinction:

> *Imagine that you are observing a member of an ethnic outgroup as an ethnic ugly slur is uttered. If you sympathize with this person's pain and discomfort, you are experiencing reactive empathy (your emotional reaction to the other's situation), whereas if you respond with feelings of indignation and resentment toward the person who uttered the slur, you are more likely experiencing parallel empathy (feeling emotions similar to those of the outgroup member)(Stephan and Finlay, 1999: 730).*

In the field of medicine, the ideas of 'detatched concern' or 'clinical empathy' are often spoken about with regard to empathy, and involve the doctor having an emotional understanding of the patient's predicament, but maintaining sufficient emotional distance so that their medical skills are not negatively impacted (Lief, 1963). Hence these clinical usages of the term are more akin to cognitive empathy. The idea of clinical empathy was built upon by Eric Larson and Xin Yao, who viewed it as a form of 'emotional labor'. They made a distinction between 'deep acting', where one would alter one's true emotions, and 'surface acting', where one would deliberately display emotions which one may not actually feel (Larson and Yao, 2005). It has been suggested that a merger of cognitive and emotional empathy is most beneficial in medicine (Halpern, 2003), with claims that 'a combination of emotional and cognitive aspects of empathy yields the most comprehensive form of empathetic understanding, combining a grasp of the other's perspective, and of what things mean to the other, with an understanding of the emotional significance of events' (Watson and Greenberg, 2009: 133).

2.1.2. Differences between Empathy and Sympathy

The differences between empathy and sympathy have been alluded to in the previous section, but since there is such debate in the literature about the two concepts, it is important to focus on these to a greater extent here. Within the literature, there are a number of closely linked perspectives on what constitutes empathy, although these differ significantly enough to cause disagreement and debate in the field. Definitions of empathy vary depending upon the field of research from which the definition stems. Within neuroscience, empathy is generally seen as feeling, imagining, adopting or simulating another person's emotional state or condition (Batson, 2009, Eisenberg and Eggum, 2009), and is heavily linked to the idea of mirror neurons in the brain (Pellegrino et al., 1992). Sympathy, however, is seen as an emotional response, and consists of feelings of sorrow or concern for another person (Eisenberg and Eggum, 2009: 71). The neuroscience perspective relates more to the natural sciences, and incorporates how empathy works in the brain, rather than in interaction.

Juxtaposed with this, empathy and sympathy have also been discussed in terms of affiliation and disaffiliation (Steensig and Drew, 2008). For example, if a woman were to go to see a doctor, she might, at some point in the consultation, say 'it just feels like it's all too much and I can't cope anymore'. An empathetic response to this utterance might involve affiliating oneself with another by saying 'I can understand it must be hard', whereas a sympathetic response might entail disaffiliating oneself by saying 'I'm sorry to hear that'. While these definitions appear different, it could be argued that the doctor is simulating, adopting or imagining another person's state, by uttering 'I can understand it must be hard', and is providing an emotional response of pity by saying 'I'm sorry to hear that'. Hence empathy can be defined both in terms of how it works in the brain, and how it is realised in interaction. The following section gives an overview of how empathy works in the brain; however, the scope of this thesis is more concerned with how empathy is realised in interaction, and this is one of the focal points of Chapter Four.

2.1.3. The Neuroscience of Empathy

Thomas Lewis (2007) proposed a neurological model of empathy, which built from the idea of empathy being an evolutionary mechanism, and involved four stages: evolution, modelling, projection and adjustment.

Evolution

The empathetic process is believed to have a strong evolutionary basis in not just humans, but mammals in general (de Waal, 2005). In evolutionary theory, mammals evolved from reptiles, in the process developing empathy as a survival mechanism due to differences in physiology. Whereas reptiles lay eggs, which are tough enough to protect the hatchlings whilst they develop, mammals give birth to live young, and hence need the parent(s) to stay and afford protection from predators. To accommodate this new cognitive capacity, the mammalian brain evolved to incorporate the limbic system, and this is the part of the brain which is believed to be responsible for emotional processing (Lewis, 2007). In addition to the limbic system, the neo-cortex also evolved, which is responsible for higher level functions such as language and logic, but its main function with regard to empathy is the mediation of emotional reactions (Goleman, 1996).

Modelling

Lewis (2007) claimed that 'people are contagious'; behaviours such as yawning (Schürmann et al., 2005), use of language (Giles and Coupland, 1991), and – most importantly to this study – emotions, are contagious. For example, Keysers et al (2004) conducted a study involving people being touched and then seeing another person being touched on the same part of the body. This then triggered activity in the same part of the brain, hence suggesting that people were modelling what they were seeing and simulating it as though they themselves were in that position. This process has been termed 'emotional contagion' and relates to the 'mirror system' hypothesis, which is a function of the brain discovered by Giuseppe de Pellegrino et al. (1992). The hypothesis suggested the existence of neurons in the brain which fire

either when a person acts or observes the same action as performed by another person. Originally, Pellegrino et al. were studying the neurons in a macaque monkey's brain, which were involved in the control of both hand and mouth motor skills. However, they also observed during this experiment that when they picked up a piece of food and began to eat it, the corresponding neurons in the monkey's brain fired. The significance of this discovery is summarised by Goleman, who claims that 'when neuroscientists decided to go beyond studying one brain and one body and one person, to look at what happens in two brains, when two brains and two bodies and two people are interacting [they] discovered circuits that they didn't even know existed. They discovered that the brain is designed to connect, is wired to connect, with the social brain of the other person' (Goleman, 2007), hence linking with the idea of empathy in interaction.

Projection

Once a model has been created in our brain, we project ourselves into it, feeling, imagining, adopting or simulating what it would be like to be in that situation. A study by Arzy et al. (2006) demonstrated this, where functional magnetic resonance imagining (fMRIs) of participants who were asked to imagine themselves in different positions showed different parts of the brain lighting up depending on what position the participant was imagining they were in. If this projection is not done, there is a danger that we might fail to understand another person's emotional state or condition. Lewis (2007) goes as far as to say that if projection is not done constantly, then a person may find themselves in the Autistic spectrum (Baron-Cohen, 2003).

Adjustment

The final stage of the model involves adjustment; adjusting the balance between your own perspective and another person's perspective. It has been argued that doctors need to have less empathy in order to do things such as stick needles in people (Lewis, 2007), and this illustrates the adjustment mechanism. If a doctor were too empathetic in this situation, they may not be able to perform the injection; hence they adjust their perspective to enable them to do things like stick needles in people,

cut them open for surgery, or amputate limbs. However, the problem with this approach is that it neglects the caring aspect of the profession; while it may be useful to mediate emotional responses in terms of the physical side of medicine, empathy is essential to the psychological, caring aspect of medicine, and the following section discusses the indispensability of empathy in the profession.

2.2. WHY EMPATHY IS BENEFICIAL TO MEDICAL PRACTICE

2.2.1. The Role of the Doctor

Since the inception of the Hippocratic Oath, there have been vigorous and extensive guidelines for how doctors should conduct themselves in the practice of medicine. These have evolved and progressed over many years, and recently have been cemented by the GMC guidelines on Good Medical Practice. In 1993, the GMC published 'Tomorrow's Doctors', which made teaching communication skills compulsory in medical schools, and one of the key aspects for good communication skills in doctors is empathy (GMC, 1993). As one of the more commonly used versions of the modern Hippocratic Oath notes 'there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug'[1] (Sritharan et al., 2001, Lasagna, 1964). This leads to a vital question surrounding the persona of a clinician: whether the core role of a doctor is to cure, or to care.[2] It is perfectly possible to cure without caring; however, patients who cannot be cured can still be cared for. It has been claimed that around 75% of healthcare costs are due to chronic conditions, such as heart disease, cancer, diabetes, arthritis and obesity (Center for Disease Control and Prevention, 2009), and

[1] While the Hippocratic Oath is still used in some medical schools, there are variations, although 98% of Americans and 50% of British medical students swear some form of oath either at the start or medical school, or at graduation (Sritharan et al., 2001).

[2] In this context, 'cure' refers to technical interventions such as drug treatment or surgery which could eradicate a problem being faced by a patient, whereas 'care' refers to the consideration of the patient's general well-being, which may incorporate treatments to alleviate symptoms and effects of a disease, but not completely eradicate the problem.

this highlights the importance and necessity of the physician's duty to care for the patient.

Relating to the caring aspect, Hippocrates believed that 'some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician' (Hippocrates, 460-400 B.C.). In relation to this, Francis Peabody (1927) claimed that 'one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient' (Peabody, 1927: 882). This sentiment was echoed by William Osler, who wrote about *Aequanimitas*; the need for a physician to be calm and accept what comes, but not to lead to 'hardness' when dealing with patients. He also noted *mental equilibrium* was essential in the balance of emotional engagment, and the need for physicians to avoid disengaging with the patient in order to protect themselves (Osler, 1932). More recent research into the area examined doctors who have been patients, and that this aids with their development of empathy; their ability to better understand what a patient is going through. (Fox et al., 2009: 1587). The study also noted that some of these GPs' experiences as patients led them to make alterations in their practice to empower their patients. Richard Frankel (2009: 1) encapsulates the above views, claiming that 'few scholars would disagree that empathy is the overarching skill that is at the heart of caring. But exactly what empathy is and how it works is still a subject of much debate'.

It would appear that by assuming the role of a doctor, one must manage empathy on at least two levels: experiencing and expressing. Whereas experiencing empathy is an element of the caring process, it is useful – especially in modern medicine – to express to the patient that this empathy is being experienced. This is a sentiment supported by Howard Spiro, who stated that 'conversation strengthens empathy. In the end, empathy is a two-way street… and it is needed as much today as ever before' (1996: 5). Therefore, it can be seen that the expression of empathy is vital to the art of caring, all be it a complex and intricate task. There are many reasons for needing to express empathy in a consultation, and these reasons link to the general motivation for requiring communication skills in medical practice and education, as well as some more empathy-specific reasons.

2.2.2. Outcomes from Using Empathy in Medical Practice

Good communication skills are closely linked with expressing empathy in a consultation, and here the two concepts are treated as such. Empathy is key to the practice of medicine, and this sentiment is elegantly encapsulated and elaborated upon in the following extract:

> *As human science and study emphasize, empathy is a necessary dimension of the work of the caregiver (physician, psychologist, psychotherapist, nurse) who wants to facilitate an efficacious result. The effects of an empathic relationship are positive both for the patient and for the physician. It can increase patient satisfaction, trust, coping skills, and compliance with therapy, while also enriching the doctor-patient experience. Moreover, if empathy is combined with competence and the appropriate setting, it can protect caregivers from burn-out and support their therapeutic power.*
>
> *... spending time listening to patients is feasible, even when the physician is busy; empathy does not take time from routine clinical work because it is embodied in the physician's overall attitude when dealing with the patient. Given that a doctor obviously cannot attend every important life event of his patients, the core condition of empathy is to share their clinical journey and seize the clues offered during examination (Anfossi and Numico, 2004: 2259)*[3].

Hence, empathy may be seen as a positive force for both the physician, and the patient, and can have many constructive outcomes for both parties.

[3] Note that this quote originates from anecdotal evidence, rather than empirical scientific research, although the sentiment summarises some of the key motivations for the presence of empathy in the doctor-patient relationship.

Diagnosis

There are numerous benefits to researching the communicative aspect of medical care, and enhancing the current training with knowledge concerning how empathy may be expressed is one of these. It has been shown that as undergraduate medical students go through medical school, their attitudes, and, as a result, communication skills, change (Woloschuk et al., 2004: 20, Hojat et al., 2009), therefore making it necessary to ensure that students are monitored and guided throughout their training in this area. Evidence suggests that the traditional, more rigid, style of consultation is not comprehensive enough to allow for full and proper diagnosis and treatment of a patient. It has been suggested that this method of consultation dissuades patients from conveying their ideas, concerns and expectations about the illness they have (Byrne and Long, 1976) and can lead to limited hypothesis testing and premature diagnosis (Platt and McMath, 1979). Hence the introduction of communication skills to medical training can aid in the accuracy of diagnosis.

Adherence

Studies have shown strong evidence regarding the link between adept consultation skills in doctors and the effect this has on healthcare outcomes, such as adherence to treatment. (Ong et al., 1995: 38, Silverman, 2009: 10). Initially, adherence to treatment was talked about in terms of *compliance*: making the patient do what the doctor told them. However, it could be argued that the term *compliance* has now been superseded by *concordance*, with an emphasis being placed upon doctor-patient communication and shared decision-making (Vermeire et al., 2001: 339). Hence there has been a shift in power, with the patient now having a more equal role in the decision making process.

Non-compliance is often a result of complex treatment regimen, and poor communication skills (Donovan, 1995). Evidently the more complex a treatment, the more adept and clear a doctor's communication must be. This is especially pertinent with 'elderly patients with memory disorders, which make them unable to follow complex sets of instructions' (Donovan, 1995: 335). It has been stated that proficient

communication from the doctor aids patient recall and understanding of the illness they are dealing with (Silverman, 2009: 161). One study showed that patients were unable to recall between one-third and one-half of statements made by doctors, evidently suggesting that this has a major impact on adherence (DiMatteo, 1994).

More specifically with regard to the role of empathy in adherence research, it was shown that if patients perceived physicians to be more empathetic, then not only was satisfaction increased, but also adherence to treatment (Kim et al., 2004). Neumann et al. (2007: 64), hypothesised a postulated effect model of empathetic communication in the clinical encounter, and listed a variety of benefits from using empathy for both the doctor and the patient. For example, they claimed that the physician's use of empathy allowed them to collect more detailed medical and psychosocial information, thus enabling more accurate psychosocial perception of the patient and a more accurate diagnosis. Furthermore, they suggested that the use of empathy permits a better understanding of the patient's individual needs, making the consultation more patient-centred. For the patient themselves, empathetic communication from the doctor can allow for the patient to feel listened to, valued, understood and accepted, as well as having feelings of isolation and worries about their problems validated.

Patient Interpretation and Satisfaction

The role of empathy in the patient's interpretation, and ultimately satisfaction, is also an area which has been researched. Maynard (2006) conducted research into patient's interpretations of diagnostic news, and found that patients would propose what they thought the news meant, and then the physician would align or disalign themselves with this interpretation. He also discovered that if a clinician withheld auspicious information, then this could be detrimental to the relationship with the patient. Another study touches upon this, and stated that through the doctor reflecting their empathic insight back to the patient, they could improve the therapeutic impact of the consultation (Zinn, 1993). A doctor not reflecting this insight back to the patient can lead to limited agenda exploration, and this was demonstrated by Barry et al. (2000). They asked a sample of 35 patients before a consultation what their agendas were; post consultation, they found that only four of

the 35 patients had voiced all of the items on their agenda. The most frequent unvoiced items included the implications of the diagnosis and future treatment, side effects of medication, and not wanting a prescription, and the paper concluded that these often led to problems such as unwanted prescriptions and non-adherence.

Research has shown that a doctor who is a good communicator will build a better rapport with a patient, thus increasing the patient's satisfaction (Taylor, 1997: 521), and dissuading them from looking for alternative solutions to their problems (BMJ, 1996: 131). It has also been reported that the length of a consultation can impact upon patient satisfaction, with reports suggesting that patients are more satisfied with longer consultations; however, this is not entirely accurate. Studies have shown that patients often misjudge the length of a consultation, with a preference for more time being correlated with a dissatisfaction regarding the emotional aspect of the consultation and an increase in non-compliance (Ogden et al., 2004). Another study showed that patient satisfaction increased when they *perceived* a consultation to last longer (partial correlation $r = 0.26$), even if it did not, and concluded that 'patient concerns about time may be as much about quality time as about actual time' (Cape, 2002: 1004). Therefore, this alludes to the idea that patients want quality of communication, not just quantity. Pollak et al. (2011) found a link between physicians who were rated as being highly empathetic with higher rates of patient satisfaction. Another study looked at the link between emotional intelligence and empathy, and showed that long-term patient satisfaction was influenced more by empathy (Weng et al., 2011). A more recent study of health centres in Ethiopia revealed some enlightening evidence about empathy across cultures. The study examined factors which were detrimental to perceived empathy on the part of the patient, and these included differences in religion, and ethnicity (Birhanu et al., 2012). The study also noted that positive associations included the patient knowing the doctor, the doctor's non-verbal behaviour, and the perceived technical competency of the physician.

Physician Well-being

Balancing the patient's emotions with those of the doctor is a difficult task, and it has been suggested that doctors may believe that their own emotional responses to patients might be seen as a lapse in objectivity (Halpern, 2001). It has been argued that this balance should sway in favour of empathising with patients rather than detaching, as this can assist with the healing process of the patient (Halpern, 2001), and this paralleled the adjustment mechanism in the model of empathy proposed by Lewis (2007). Further work in the area highlighted the distinction between empathy in medicine and empathy in other areas. One paper argued that in the field of medicine, empathy is often defined as a form of detached cognition, whereas outside the field it is deemed to incorporate emotional resonance (Halpern, 2003). It continued to propose that the two concepts were not mutually exclusive, and that a doctor's emotional attunement could aid with the cognitive aspect of understanding how the patient is feeling, or what they are thinking. A follow up study aimed to describe how doctors could empathise with patients while experiencing emotional resonance. The research highlighted the need for doctors to recognise and attend to their own emotions, as well as those of the patient, and that these techniques can reduce anger and frustration on the part of the doctor (Halpern, 2007). This has also been supported in other studies (Platt and Keller, 1994) which note that alleviating these negative emotions can improve the therapeutic impact of the consultation for the patient. Suchman et al. (1993) looked at elements which affected physicians satisfaction with consultations in primary care. They found four aspects deemed to contribute to satisfaction, and these included the physician's satisfaction with the relationship with the patient, the information given by the patient, the appropriate use of allocated time and the patient not making excessive or unreasonable demands. Another study explored how physicians coped when working with terminally ill patients, and identified a variety of coping mechanisms. These included dehumanising the patient, directing anger toward the patient, and 'going numb'. The study concluded that providing physicians with a forum to discuss their troubles may help to develop more productive coping mechanisms (Schulman-Green, 2003). Other suggestions include an 'unstructured contemplation of the humanities as a means of ensuring empathy and compassion in physicians' (Skelton et al., 2000: 2001), and

this may lead to improvements in the bibliotheraputic and empathetic aspects of the physician's well-being.

Litigation

A breakdown in doctor-patient communication may not only lead to the patient being unsatisfied with the care being received, but also may encourage them to file legal claims (Bruce, 2004, Hickman et al., 1994). It has been suggested that over 80% of malpractice lawsuits emanate from issues surrounding a doctor's communication skills (Shaw, 2005). A recent longitudinal study examined malpractice claims in relation to a physician's speciality in the United States. The results of the study showed that 7.4% of physicians had a malpractice claim between 1991 and 2005, with 1.6% paying out to claimants. The mean cost of these payments was $274,887, with the median being $111,749, and the authors estimated that by the age of 65, 75% of physicians working in low-risk specialities would face a malpractice claim, compared with 99% in high risk specialities (Jena et al., 2011: 629). It has been claimed that 'in the past 30 years, medical malpractice has become one of the most difficult health care issues in the United States. In addition to billions of dollars in legal fees and court costs, medical malpractice premiums in the United States total more than $5 billion annually' (Moore et al., 2000: 1), thus showing a doctor's communication skills can have economic, as well as medical, consequences. This highlights the need for medical students to be taught how to communicate effectively with patients, and is something that the GMC now insists upon in their guidelines for good medical practice (GMC, 2009).

Therefore, it can be seen that the teaching of communications skills is paramount in producing proficient doctors and medical professionals, although some of these skills, such as the expression of empathy in consultation, require further, more extensive, research and implementation, particularly with regard to how these skills are taught through consultation models.

2.3. TEACHING AND LEARNING EMPATHY IN MEDICAL EDUCATION

The cognitive capacity for empathy is believed to begin around the age of two (Zahn-Waxler and Radke-Yarrow, 1990), and that reinforcement of empathetic understanding continues throughout life. For example, the majority of religions attempt to instil empathy into followers, with the aim being to teach morals about how humans should interact and treat one another. Hence, the best and most logical way of doing this is to help them understand what others are feeling and thinking: using empathy. This is apparent in Christianity: 'do unto others what you would have them do to you' (Matthew 7:12), The Qur'an, The Oral Torah, and the vast majority of religions throughout the world. Neurological studies have demonstrated that the orbitofrontal cortex, which is responsible for a number of empathetic mechanisms, is still developing in humans well into their mid-20s (Goleman, 2007), and this complicates teaching empathy to medical students, a large proportion are under 25 for the duration of their training in consultation skills at the UEA.

It has been suggested that empathy is not a teachable phenomenon (Davis, 1990), although studies since have shown that communication skills interventions do increase medical students' empathy (Fernández-Olano et al., 2008, Stratton et al., 2005, Hart et al., 2006). Fadlon (2004) revealed some of the problems students have with the teaching of consultation skills, aptly titling the paper 'teaching medical students what they think they already know' (Fadlon et al., 2004: 35). The paper advocates a more structured model for teaching students, as they can often see the communciation aspect of medicine as unspecialized, repetitive and boring. Other studies have encouraged consultation skills to be taught through role-playing (Newton et al., 2000), and this is the approach currently adopted at the UEA.

The most widely used method of teaching consultation skills in the United Kingdom is the Cambridge/Calgary model, which is used in around 60%-70% of medical schools (Silverman, 2007: 87), and is the current model used at the UEA. The model is built around helping the doctor build a positive relationship with the patient, while at the same time providing structure and leading the consultation. One of the core aspects involves the doctor attempting to elicit the ideas, concerns and expectations

of a patient (commonly referred to as ICE), thus making the consultation more patient centred. To provide structure, the model advocates signposting, where the doctor would preface a long string of information with an explanation as to why this section of the consultation is necessary. Moreover, it advises summarising the information that the patient has been given, using strategies such as chunking and checking, where the doctor would concept check and break the information down into easily understandable segments. Finally, screening involves probing the patient for any further worries or doubts they have about the consultation, thus complimenting the patient centred approach.

For the specific empathetic content of the model, the acronym '**RAV**' is used, which stands for **R**ecognise, **A**cknowledge, **V**alidate. '**R**ecognising' alludes to the idea of empathetic mechanisms within the brain simulating emotions (either consciously or sub-consciously) and recognising this on a conscious level. The main focus of this thesis however, is more closely involved with the second and third elements. The difficulty here is what strategies are best to use when **A**cknowledging. One of the more frequent strategies used by medical students is to utter the generic phrase 'I can understand. It must be very hard for you'. Arguably, this is not the most felicitous speech act; the lexis utilised does not properly reflect an in depth understanding of what the patient is going through, and the fact that the phrase is non-specific to the patient detracts further from genuine empathetic communication. It is clear that further research in this area is required, where medical students must gain a broader understanding not just of the linguistic strategies that may be utilised in specific scenarios, but a more complete appreciation of the dynamics of the consultation.

Another predicament is with the '**V**alidation' of emotions, which are often confused by medical students with validating why the patient has come to see the doctor. The validation of emotion should entail the doctor expressing how they understand the emotions felt by the patient, and how they are simulating the emotions that the patient is feeling. However, this then becomes more complex: if a doctor is simulating an emotion they have never felt before, it raises the issue of whether they can effectively and accurately understand and simulate the emotion. Furthermore, if the doctor has felt the emotion before, they have a decision to make regarding

divulging personal experiences to the patient to show how they understand what they are going through, or remaining detached to a certain extent, to maintain a professional relationship. It is these issues surrounding the expression of empathy which are the main focus of this thesis.

CHAPTER THREE: OVERVIEW OF THE LITERATURE

3.0. INTRODUCTION

This chapter begins by dicussing measures of empathy in medicine, involving the various scales and tools that have been utilised in the field. It notes that while these scales can attempt to measure empathy, they generally do not tell us how it is expressed in interaction. The chapter proceeds to discuss some of the more general qualitative research conducted in the field, although the qualitative papers most relevant to this thesis are the focus of a structured review and critical appraisal in Chapter Four, hence only a broad overview of the qualitative resaerch is given here.

3.1. MEASURES OF EMPATHY IN MEDICINE

Since the introduction of more formal communciation skills training in medical schools (GMC, 1993), there has been an explosion of interest in related fields, especially with regard to the emotional and empathetic aspect of the consultation. In the mid-90s, the state of this aspect was discussed by Duan and Hill (1996), who noted that there had been a 'decrease in empathy research... attributable to the lack of clear focus and effective research tools' (Duan and Hill, 1996: 261). Since then, a wave of papers have been published on the topic, with many of these stemming from the field of medicine. There have been a number of systematic reviews, which examine the empathy tests and instruments used in medicine (Hemmerdinger et al., 2007), and the impact of emotion skills training for medical students (Satterfield and Ellen, 2007). More recently, Pedersen (2009) conducted a critical review of empirical research in medicine, and there has also been research into the decline of empathy amongst students and residents (Neumann et al., 2011). It is clear from these reviews that there is an extensive amount of studies concerning empathy in

medicine which take a quantitative approach to the subject, and these papers are discussed in more detail in the following section, with information about the measurements, how they have been used, and what they have found being detailed.

3.1.1. Jefferson Scale of Physician Empathy (JSPE)

The Jefferson Scale of Physician Empathy (JSPE) was developed at the Jefferson Medical College (Hojat et al., 2001), and measures empathy in physicians, medical students, health professionals, and other health-related workers. The scale itself consists of a self-administered 20-item test, which uses a 7-point Likert scale, and the questions included in the scale relate to three broad areas: perspective taking, compassionate care, and standing in the patient's shoes. There has been a multitude of work pertaining to the validity of the scale (Hojat et al., 2005, Fields et al., 2004, Glaser et al., 2007), with the results suggesting that it is an accurate measure of empathy.

One of the most prominent findings through the use of the JSPE is the change in empathy which occurs during the course of medical school. One study showed significant declines in 5 items on the scale ($P < 0.01$), and the overall scores on the scale ($P < 0.05$) between tests administered at the beginning and end of the third year of medical school (Hojat et al., 2004). This erosion of empathy over time was also found by Chen et al. (2007), where empathy was measured using the JSPE across the medical school years at Boston University Medical School. The study showed that first year medical students had the highest empathy scores (118.5), with the fourth year students obtaining the lowest scores (106.6). Moreover, the study also found that empathy decreased between the second and third year classes (118.2 vs. 112.7, $P < 0.001$). A decrease in empathy during the third year of medical school was further supported in other research, where it was observed that empathy scores remained constant for medical students in years one and two, but that there was a significant decline in JSPE score for third years (Hojat et al., 2009). A more recent study addressed this issue, and suggested that preserving levels of empathy over the course of the third year of medical school was possible through educational intervention,

and that this was achieved through providing the students time to discuss their reactions to certain situations they had found themselves in over the course of their studies (Rosenthal et al., 2011).

Another prominent finding from the use of the JSPE involved the differences between gender and empathy. Chen et al. (2007) found that females had higher JSPE scores than males (116.5 vs. 112.1, $P < 0.001$). The study also indicated that those students pursuing the people-oriented specialities (defined within the article as primary care/general practice) scored higher on the scale (114.6 vs. 111.4, $P = 0.002$), with female medical students being more likely to pursue these pathways (51.5 vs. 26.9%, $P < 0.001$). Another study used the student version of the JSPE (JSPE-S) and found that women had higher scores than men, and that empathy decreased over the course of attending medical school (Chen et al., 2012). The finding that women scored higher on the JSPE was supported by Hojat et al. (2002b), and also showed that psychiatrists scored a mean empathy rating which was significantly higher than those who had opted for technology-oriented specialities, such as anaesthesiology, orthopaedic surgery, neurosurgery and radiology. This link was also shown in other studies (Hojat et al., 2002a). Juxtaposed to the above findings, Kliszcz et al. (2006) found no significant differences between genders when using the JSPE to test differences between physicians' and nurses' empathy. The results did however indicate that physicians obtained the highest mean empathy score (113.06 vs. 110.12). Austin et al. (2007) combined the JSPE with a 41-item Emotional Intelligence Scale and found a significant difference between gender and empathy; however, unlike other findings, this study showed that male empathy increased between the first and second year of medical school, whereas female empathy declined.

In addition to measuring differences in empathy between gender and cohort, the JSPE has also been utilised in assessing the efficacy of communication skills training. Fernández-Olano et al. (2008) conducted a quasi-experimental pre-test/post-test study using a control group and an experimental group, with the intervention for the experimental group being a 25 hour communication skills workshop. The mean JSPE score for the pre-workshop was similar in both groups; however, post-

workshop, the experimental group's mean empathy score increased 5.24 points (95 CI 3.82-7.09, P < 0.0001), improving in 68.9% of the participants, while the control group showed no significant increase. Another study demonstrated the efficacy of an intervention, with the baseline empathy scores significantly increasing post-intervention (Lim et al., 2011). In contrast to these Mangione et al (2002) found no statistically significant differences in JSPE scores among residents of different training levels, and concluded that 'empathy is a relatively stable trait that is not easily amenable to change in residency training programs' (Mangione et al., 2002: 370). This was also the case with a study examining how Balint training can affect levels of empathy (Cataldo et al., 2005)

3.1.2. Interpersonal Reactivity Index (IRI)

The Interpersonal Reactivity Index (IRI) stems from the work of Davis (1983, 1980), and it is a measure which considers empathy to comprise of a set of separate but related constructs. The instrument itself consists of four 7-item subscales, involving perspective taking, empathic concern, personal distress, and fantasy scales. Perspective taking pertains to one adopting the psychological viewpoint of another, empathic concerns involves experiencing feelings of sympathy and compassion for others, personal distress is the tendency to mirror distress and discomfort, and fantasy is the capacity to imaginatively transpose viewpoints into fictional situations.

The IRI has been used to examine how enthusiasm at the start of medical training depletes over time. Bellini et al. (2002) found that interns showed better baseline scores for perspective taking (P < 0.001) and empathic concern (P < 0.001), and lower scores for personal distress than would usually be expected. However, by the fifth month of the internship, personal distress increased (P < 0.001), and empathic concern decreased (P < 0.005), with further changes continuing throughout the internship. They concluded that the 'enthusiasm at the beginning of internship soon gave way to depression, anger, and fatigue' (Bellini et al., 2002: 3143). A follow up study (Bellini and Shea, 2005) showed decline in empathic concern, but that personal distress peaked, unsurprisingly, mid-internship. Other studies have shown that medical students' empathy levels are consistent with the general population

norms (Evans et al., 1987, Coman et al., 1988); however, one study (Rosen et al., 2006) which measured medical students' empathy levels at baseline and end of year found that scores were more favourable at baseline than general population norms ($P < 0.001$), but that this returned to normal levels at the end of the year ($P = 0.15$).

Thomas et al. (2007) found that medical student scores of the JSPE were higher than the norm, and that personal accomplishment ($P < 0.0001$) and a high quality of life ($P < 0.05$) demonstrated a positive correlation with empathy. However, factors such as distress and the students' well-being correlated with decreased levels of empathy. This is supported by Shanafelt et al. (2005), who found a statistically significant difference on the perspective taking scale, with a higher level of mental well-being positively influencing levels of empathy in students. Relating to this, another study found that reduced empathy and increased burnout in internal medicine residents increased the chance of them making self-perceived errors in the following three months (West et al., 2006).

Other studies have utilised the IRI to different ends. Stratton et al. (2005) showed the impact of communication skills training was positively correlated with empathy, particularly empathic concern and perspective taking ($P \leq 0.05$). Similarly to findings reported using the JSPE, the IRI has also returned results indicating that women are more empathic than men in the first and final year of medical school, although women's empathy decreased slightly, whereas the male's cognitive empathy increased (Kliszcz et al., 1998). Finally, West et al. (2007) showed that as medical students' medical knowledge increased, their empathic concern decreased over the same time period (mean decrease 1.6, $P = 0.0003$), although no significant correlation was found between these variables.

3.1.3. Roter Interaction Analysis System (RIAS)

The Roter Interaction Analysis System (RIAS) was devised in the late 1970s, and, although there have been criticisms of its rigid coding categories (Cox et al., 2008), overall it is a popular instrument within medical and health contexts (Roter, 1989, Roter and Larson, 2002). The system is used to code audio or video data of doctor-

patient interaction. Thirty-eight mutually exclusive categories are used to code elements of the interaction, which can range from a single word to an entire clause, and it also includes a 6-point Likert scale, where coders rate the overall emotional context of the interaction. Ratings can be assigned for both the doctor and patient, with one of the 13 listed affects being 'empathy' (Pedersen, 2009: 311).

The RIAS has shown differences in empathetic sequences. One study showed that when responding to a patient's concerns, a doctor would utilise a facilitative, rather than empathic, response. When empathetic responses did occur, they came predominantly immediately after the patient expressed a concern, rather than waiting until later in the consultation (van den Brink-Muinen and Caris-Verhallen, 2003). Another study elaborated upon this, examining potential empathetic opportunities using the RIAS, and demonstrated that the category 'showing concern' was most commonly associated with empathetic opportunities (Eide et al., 2004). This work links with that of Suchman et al. (1997), which is discussed at greater length in Chapter Four.

Another area which the RIAS has been used to explore is the patients' satisfaction with clinicians' communication. Passche-Orlow and Roter (2003) found that some clinical settings lean more to using different types of question; for example, family practice clinicians engage in more psychosocial discussion ($P = 0.02$) and use more empathy and reassurance strategies ($P = 0.06$), and that this can impact upon patient satisfaction. However, other studies have found that the affective aspect of the consultation does not differ significantly in relation to clinical setting (van Dulmen, 2002). With regard to what makes a physician appear to be empathetic, adequate responses to concerns were not associated with increased empathy, suggesting that the patient's perception may 'not be an adequate measure for what has actually taken place during that visit' (van Dulmen and van den Brink-Muinen, 2004: 149). Finally, a study showed that alexythemic patients' satisfaction increased when physicians responded more empathetically, but that the non-alexythemic patients were most satisfied with a longer length of consultation (Graugaard et al., 2004).

Other studies have used the RIAS to examine the efficacy of consultation skills training. One study reported that residents used more effective communication in a parent-provider consultation following an intervention ($P < 0.5$) and that the parents' satisfaction with the residents' communication also increased ($P = 0.05$), although their overall perception of the residents communication stayed constant (Hart et al., 2006). Other communication skills interventions have shown decreases in verbal dominance, more open-ended questions and greater empathy from residents (Roter et al., 2004).

3.1.4. Hogan's Empathy Scale

Hogan's empathy scale is a 64-item self-report measure of empathy (Greif and Hogan, 1973, Hogan, 1969), which was later adapted to include a 7-point scale pertaining specifically to medical student/physician empathy (Hornblow et al., 1977). A longitudinal study which used Hogan's scale showed a decline in empathy for students of the Bowman Gray School of Medicine between 1975 and 1979 (Diseker and Michielutte, 1981). Results indicated that this was unrelated to academic performance, and this finding was also apparent in a study by Kupfer et al. (1978) who found that there was not a strong relationship between MCAT scores and empathy scores on the scale, although certain personality traits such as anxiety and depression had a negative correlation with being empathetic.

3.1.5. Barrett-Lennard's Relationship Inventory (RI)

The Barrett-Lennard Relationship Inventory (RI) contains an empathy sub-scale, which includes three phases: inner empathetic understanding, expressed empathetic understanding, and received empathy (Barrett-Lennard, 1962, Barrett-Lennard, 1976). While the scale is predominantly used in psycho-social research, some studies have used it in a medical context. Free et al. (1985) used the scale to highlight the disparity between patients and healthcare workers' agreement as to what empathy constitutes. Another study examined the non-verbal aspect of the consultation, and found that a physician's avoidant gaze and lack of back-channelling resulted in lower ratings of interviewer empathy (Marci and Orr, 2006).

3.1.6. Consultation and Relational Empathy (CARE)

The Consultation and Relational Empathy (CARE) measure was developed by Mercer et al. (2004), with a patient answering a set of ten statements relating to a doctor's empathy on a 5-point scale. The scale has been used to show that empathy is essential for patient enablement, and that a patient's perception of empathy itself is related to how long a consultation is (Bikker et al., 2005). An updated version of the CARE scale (CQI-2) supported this idea, with GPs who had higher CQI-2 scores valuing empathy and longer consultations more than the lower scoring GPs (Mercer and Howie, 2006). The results also indicated that the patients of doctors with lower CQI-2 scores had less confidence and satisfaction with their consultation. Another study carried out on 3,044 patients at both ends of the socio-economic spectrum used the CARE measure to show that perceived empathy had a positive effect on enablement in both cases (Mercer et al., 2012) .

3.1.7. Balanced Emotional Empathy Scale (BEES)

The Balanced Emotional Empathy Scale (BEES) stems from The Questionnaire of Emotional Empathy (QMEE). It is a 30-item self-report scale, with a 9-point agreement/disagreement scale (Mehrabian, 2010). Similar to findings from other scales, the BEES scale has shown that empathy declines during the course of medical school, and that the choice of speciality can significantly affect how empathetic a doctor is (Newton et al., 2000). It has been noted that empathy significantly decreased ($P < 0.001$) especially after the first and third years of medical school (Newton et al., 2008). Some research has shown that this decline in empathy can be combated with training (Elizur and Rosenheim, 1982). Shapiro et al. (2004) combined the BEES with LaMonica's Empathy Construct Rating Scale (ECRS) and found that the student's understanding of the patient perspective became more detailed and complex after consultation skills training. The study also noted the link between empathy and the humanities, with students more likely to acknowledge the role literature could play as a coping mechanism post-intervention.

3.1.8. Accurate Empathy Scale and Carkhuff's Empathic Understanding Scale

The decline of empathy during medical school has been shown with the Accurate Empathy Scale. Before consultation skills training was formally introduced (GMC, 1993), Poole and Sanson-Fisher (1979, 1980) found that accurate empathetic responses to patients were at a minimum level, and that this did not improve during undergraduate training. However, when an intervention was introduced, although the medical students' empathy still declined, it was still at a higher level in the experimental group. This increase in empathy was also found by Fine and Therrien (1977). The Accurate Empathy Scale was revised and renamed to Carhuff's Empathic Understanding Scale (1969), and showed a significant correlation with the RI scale (Jarski and et al., 1985). A study using this adapted scale showed that consultation skills interventions can increase the use of open-ended questions and emotion related responses amongst junior doctors (Kauss et al., 1980).

3.1.9. Other Scales Used to Measure Empathy

In addition to the above, there are a number of other scales which have been utilised to measure empathy in medicine. These are not discussed in as much detail as the above, but are described adequately elsewhere (Pedersen, 2009, Hemmerdinger et al., 2007).

With regard to interventions changing levels of empathy, one study using a pencil and paper empathy test showed that there was no increase after a training programme (Moorhead and Winefield, 1991). In contrast, a related study indicated that medical students (81%) felt more comfortable leading a consultation after training (Winefield and Chur-Hansen, 2000), although 30% of the students showed no gains in their empathetic ability. Walters et al. (2007) adopted a 5-point Likert scale to measure empathy, and demonstrated that after training GP registrars exhibited more empathy (2.3 vs. 3.0, P = 0.03). This was echoed in another study, which used the Affect Reading Scale to show that after a short communication skills training course, students scored a higher mean overall empathy score (Holm and Aspegren, 1999). Finally, a significant change post-communication skills training was shown by Dow

et al. (2007), who used an Instrument Resident Communication Evaluation Form to show that an intervention group had better post-test scores in 5 of 6 sub-scores than the control group ($P \leq 0.01$).

Findings from other studies also support the differences between empathetic ability and gender. A mixed multivariate analysis of variance (MANOVA) indicated that female physicians were perceived to communicate empathy more efficiently than males (Nicolai et al., 2007). These findings were supported by Bylund and Makoul (2002), who also revealed that females were more adept at responding to empathetic opportunities. Pollak et al. (2007) examined empathetic opportunities in oncology, and found that gender was related to the number of empathetic opportunities, with female patients seen by female oncologists having the most ($P = 0.03$).

3.1.10. Summary

From the quantitative literature above, there appear to be a number of overlapping conclusions from the various scales. These include differences in empathy between gender, (with females generally being more empathetic), changes in empathy during medical school (most notably a decline in empathy as clinical knowledge increases), and the efficacy of interventions such as communication skills training, with varying results. It is surprising then, that given the interest in empathy, and the development of such a magnitude of scales, that very little of the quantitative research examines how empathy is realised in a communicative capacity. The RIAS does allude to this, but empathy is very much a secondary focus with this tool. Perhaps this is a limitation of the quantitative research; given empathy's subjective nature, it could be argued that assigning numbers to an abstract noun is not the widest encompassing method of assessment. While quantitative studies can show levels of empathy and shifts in empathic attitudes, they cannot account for the actual process through which empathy is communicated. Pedersen (2009) comes to a similar conclusion, claiming that:

> *'Empirical research on empathy in medicine is dominated by relatively narrow quantitative methods that include the physician's and the*

> *patient's concrete interpretations, feelings, and experiences to a limited extent. Furthermore, the possible influences of medical training and working conditions on empathy have not been adequately explored. In sum, the empirical studies of empathy tend to separate empathy from main parts of clinical perception, judgment, and communication. Thus, important aspects and influences of empathy have been relatively neglected' (Pedersen, 2009: 318).*

In order to address these issues, the in-depth qualitative research in the field must be reviewed and the findings amalgamated. The next section discusses some of the more general research which has been done in the field, while Chapter Four builds on this with a structured review of the qualitative literature most relevant to the research questions in this project.

3.2. INTERACTIONAL REALISATIONS OF EMPATHY

3.2.1. Empathetic Opportunities

In addition to the measures developed to examine empathy in medicine, many papers have approached the topic from an alternative standpoint, such as from a qualitative perspective or a philosophical contemplation of empathy's applicability to medical practice and education. An early attempt to build a model of empathetic understanding in medicine came from Squier (1990), who developed a theoretical framework of the doctor's understanding, the patient's knowledge, and consultation outcomes. This was built upon to introduce the idea of 'windows of opportunity', where the doctor had the chance to display empathy and show his or her understanding of the patient's concerns (Branch and Malik, 1993). Further work examined patient clues and the responses given by doctors. One study (Levinson et al., 2000) conducted a qualitative analysis of 116 primary care and surgery settings. The results showed that over 50% of visits included one or more clues from the patient, with 70% of these being initiated by the patient, and 30% by the physician. The findings also revealed that these opportunities were frequently missed (only 21% responded to in primary care, 38% in surgery), and this relates to the

examination of missed empathetic opportunities in other papers (Suchman et al., 1997, Morse et al., 2008), which are discussed in more detail in Chapter 4. A more recent study conducted a phenomenological study of medical students' experiences of empathy in patient care (Tavakol et al., 2012). The conclusions indicated that although empathy may be seen as an innate cognitive mechanism, it may be enhanced by educational interventions.

3.2.2. Empathy in Interaction

More recently, Drew et al. (2001) advocated the use of Conversation Analysis as a method for scrutinizing interaction in healthcare settings. In relation to empathy, this has been used in a number of instances. Wynn and Wynn (2006) examined empathy as an interactionally achieved phenomenon in psychotherapy, and found that a patient may receive empathy by answering questions, agreeing with assertions, demonstrating their understanding, and an appropriate display of their feelings. Failure on the patient's part to act in such a manner may result in a communicative breakdown, shown through reformulations, pauses and topic shifting. The subject of topic shifting in medical consultations has been examined in more depth (Campion and Langdon, 2004), and found that patients would utilise two distinct methods to achieve a change in topic. These included the use of a 'pre-announcement', where the patient would announce – usually at the start of the consultation – that they had multiple topics to cover, and 'in-situ announcements', where the patient would unexpectedly change topics during the consultation. The findings demonstrated that topic shifting was commonplace in medical practice, occurring in nearly one third of the consultations, and that physicians routinely managed these instances, and structured the consultations to understand, and meet, the wants and needs of the patient.

Other papers employing CA (Ruusuvuori, 2007, Ruusuvuori, 2005) showed that during Finnish homeopathic and general practice consultations, both the doctor and patient maintained an element of neutrality with regard to emotions, but that the affiliative practices of the doctor were adjusted to incorporate this. Pudlinski (2005) looked at empathetic and sympathetic responses in a peer support telephone

conversation. He found that the emotional content of the interaction typically occurred near the start of the consultation, and responses included reporting one's own reaction, naming the feelings of the other, and sharing similar experiences. Other papers, more relevant to the aims of this thesis, have also used Conversation Analysis as a methodology to examine empathetic communication (Martinovski et al., 2007, Cordella and Musgrave, 2009, Harres, 1998, Wynn, 2005), and these are discussed in Chapter Four at length. Further research in the area is forthcoming (Heritage and Lindström, frth).

3.2.3. Summary

This chapter has provided an overview of the literature. The scales that have been developed to measure empathy in medical students and the difficulties in recognising where empathy is required in interaction have been discussed. The next chapter builds on this through a structured review of the literature which includes the papers which are most relevant to the aims of this thesis: papers which examine expressions, or perceived expressions of empathy in medicine.

CHAPTER FOUR: STRUCTURED REVIEW OF THE LITERATURE

4.0. INTRODUCTION

This section outlines how the qualitative literature has been searched and synthesised, with the intention of ensuring that this research adds to the existing body of knowledge. The aim of the section is to examine papers which are *almost* synonymous with the research question in this thesis: those which discuss or are concerned with how empathy is perceived to be expressed. Due to the multi-faceted topic under scrutiny, a wide array of disciplines needed to be covered, and these ranged from topics contained within the fields of linguistics, sociology and psychology to medical and health communication. Strict search criteria were therefore imposed in order to find only the most relevant papers. The following sections detail the strategies used to search for the literature, including the database selection, descriptor selection, limiting the search results and how the data were synthesised.

4.1. SEARCH STRATEGY

4.1.1. Database Selection

The academic fields deemed most relevant to this study included language, non-verbal behaviour and healthcare communication. To cover this spectrum of topics, the following databases were searched separately: for general healthcare communication, 'MEDLINE'; for literature relating to language and linguistics, 'Linguistics and Language Behaviour Acts' (LLBA); for literature on gesticulation and non-verbal behaviour, 'PsycINFO'; and for literature relating to the sociological side of empathy, 'Applied Social Sciences Index and Abstract' (ASSIA). Both

MEDLINE and PsychINFO were searched using the OVID search engine, whereas LLBA and ASSIA were searched using the CSA Illumina engine. The reason for searching the databases individually, and not compiling results through a CrossSearch engine, was that the databases used have differing methods of truncating. For example, some use a '$', and others use a '*', and this could have hindered search results, hence it was more thorough to search the databases individually. In addition to these databases, a number of additional papers were identified from hand-searched literature, relevant bibliographies, literature recommended by colleagues, and zetoc alerts, and these were included in the final search results.

4.1.2. Descriptor Selection

Having determined the overall aim of this project was to explore how **empathy** is perceived to be **communicated** in scenarios where medical students **consult** with a simulated patient, a number of areas had to be covered in the literature search in order to find literature relevant to this project. Hence, **empathy**, **communication** and **consultation** were the overall subject areas which the search covered. The range of four databases meant that different subject headings had to be used to search the literature. For example, in the Medline database, the term 'patient consultation' was used, but yielded few results, and this was due to different databases using alternative descriptors to refer to varying topics. The situation was further complicated as this project deals with abstract ideas such as empathy, and many people (who design these descriptors) may have differing interpretations of what 'empathy' consists of, or indeed whether alternative terms are used to describe the phenomenon. This problem was solved to an extent through finding synonyms for the above terms, which were looked up in the databases' internal thesauri, a stand-alone thesaurus, and brainstormed to ensure that the results yielded from the search were as complete and comprehensive as possible. This also helped to ensure consistency throughout the search strategy of the various databases.

Particular terms that were originally identified as being relevant to this search were omitted from the final list of descriptors, as they returned too many irrelevant results

due to their versatile usage in the English language. These terms were ‘dialogue’, ‘council’, ‘meeting’ and ‘clinical’ which were used as synonyms of ‘consultation’; and ‘language’, which was used as a synonym for ‘communication’ (the initial combined results with the inclusion of these terms returned almost 5,000 hits). Since the project predominantly revolves around the concept of empathy, it was decided that the truncation ‘empath*’ would be utilised as an individual descriptor, to ensure that any results that were returned involved the concept on at least some level. Table 1 demonstrates the search terms that were used (note that an asterisk at the end of the term denotes a truncation):

Table 1. Descriptors used to refer to the three main search terms.

EMPATHY	COMMUNICATION	CONSULTATION
empath*	discuss* or discourse* or conversation* or gest* or non-verbal* or verbal* or express* or communicat* or morpholog* or gramma* or lexi* or phonem* or phonet* or phonol* or pragmatic* or psycholinguist* or semantic* or semiotic* or sociolinguist* or synta* or utterance or inter-action or grice or maxims or politeness	appointment* or consultation* or meeting* or OSCE*

4.1.3. Limiting the Search Results

The collection of terms for the main subject headings were queried separately in each database firstly using the 'OR' function to expand the overall search results. The hits for all three of these terms were then combined using the 'AND' function. Limits were then imposed on the hits, and these included the following:

- Limited to 'abstract'.
- Limited publication year from '1993 to present'.
- Limited results to 'English language'.

By limiting the parameters to the abstracts, only the key papers that were most applicable to this study were drawn up. Moreover, the reason for limiting the publication date was not only to make sure that only the most recent papers were considered for review, but also because it was in 1993 that the GMC published 'Tomorrow's Doctors', which advised that all undergraduate medical students must undergo communications skills training as a part of their programme (Kurtz et al., 2005: 2). Finally, the papers were limited to English language, as this thesis is only concerned with empathy expression in consultations being conducted in this language. Papers written in English, but with a focus on empathetic expressions in other languages (Ruusuvuori, 2005) were also not included in these search results, but are referenced elsewhere in Chapter Three. Where the databases would allow, the results were limited to any methodology involving qualitative research. Once these limits had been imposed on the results, the search was refined by combining the results with the following search terms: 'doctor* or physician* or practitioner* or student* or GP*'. These terms were not limited to the abstract, so that any paper with the above criteria that mentions doctors remained in the search results. This ensured to the greatest extent possible that only papers that were related to doctor or student doctor consultations were retrieved, omitting any papers that may have consultations with psychiatrists, dentists or other modes of consultation.

The remaining results were skimmed for exclusion by title, then abstract and then a full reading of the paper against the following criteria:

- Limited to research concerning how empathy is *expressed* or *perceived* to be expressed.
- Limited to papers explicitly concerned with empathy (some papers broadly referred to the concept of empathy, but the main focus of the paper related to other aspects of communication).
- Limited to research involving doctors/medical students.

By limiting the search to how empathy is expressed, any paper concerned with the neuroscience of empathy was omitted. Although these papers were relevant to this project, they did not address the main aims and objectives of the research, hence why they have been covered in previous chapters as a prelude to this structured review of empathy in consultations. Furthermore, papers that were not explicitly concerned with empathy expression were excluded. Many of the papers returned mentioned empathy as an after-thought of how communication skills training could be improved, whereas the paper itself did not concern itself explicitly with the concept of empathy. Finally, only papers which involved doctors and/or medical students were included (for any papers that may have eluded the previous search filters).

4.1.4. Synthesising the Data

The following section details the process of the literature search. Table 2 demonstrates the various stages of the search strategy, with the number of hits being recorded for every individual search that was completed. Only the PsycINFO database allowed for results to be filtered by methodology, hence it is the only one containing a result for that parameter; all other databases had to be filtered by methodology manually.

The results from this search were then synthesised in accordance with the limitations to only include papers dealing with expressions of empathy, explicitly concerned with empathy, and involving doctors/medical students. Against these limitations, 37

papers were excluded by title and 42 papers by abstract. After reading the papers in full, eight were deemed to be close enough to the aims of this project to warrant reviewing. In addition to this search strategy, literature deemed relevant to the study was included that had been hand searched, as well as literature that had been recommended by colleagues, supervisors, peers and zetoc alerts. These included two papers (Martinovski et al., 2007, Morse et al., 2008) that were not returned in the structured search strategy. Hence the overall number of results eligible for review was ten. These papers are critiqued in the following section to decipher how this project augments and builds upon existing knowledge.

Table 2. Results from the structured literature review search strategy.

DATABASE	**MEDLINE**	**PsycINFO**	**LLBA**	**ASSIA**
Search engine	OvidSP	OvidSP	CSA Illumina	CSA Illumina
Hits for Descriptors of *Empathy* in Abstract	4,421	14,268	502	1,674
Hits for Descriptors of *Communication* in Abstract	2,399,910	838,857	243,703	103,204
Hits for Descriptors of *Consultation* in Abstract	71,720	42,907	3,517	8,710
Combined Hits for Descriptors of *Empathy*, *Communication* and *Consultation* in Abstracts	128	195	11	26
Limited to English Language	114	173	8	26
Limited Publication Between 1993 and Present	103	140	8	25
Limited to Qualitative Research Methodologies	-	21	-	-
Combined Hits with Descriptors of *Doctor*	76	16	7	12

Total Results (duplicates removed): 91

Table 3. Summary of qualitative studies detailing empathic expressions in medical education and/or consultations.

REFERENCE	METHODOLOGY	DATA	PRIMARY FINDINGS
Cordella and Musgrave (2009)	Conversation Analysis	OSCE data	Empathy expressed through turn-taking, lexical choice and sequential organisation.
Coulehan et al. (2001)	n/a	Theoretical	Choice of lexis can affect empathic tone of a consultation.
Harres (1998)	Conversation Analysis; focus on tag questions	Audio recordings of doctor-patient interaction	Tag questions open up consultation to patient, allowing them to discuss ideas, concerns and expectations. Use of 'we' also considered an empathic device.
Martinovski et al. (2007)	Conversation Analysis; focus on rejection of empathy	Corpus data	Empathic process involves ‘empathizee’ and ‘empathee’, and is ordered in sequences.
Morse et al. (2008)	Grounded Theory and Phenomenology	Transcripts of doctor-patient interaction	Empathic responses to patient concerns rare; when they did occur, was usually in the final third of the consultation.
Norfolk et al. (2007)	Phenomenology	Interviews	Stages of empathy = empathic motivation, attention, and interpretation.
Roberts et al. (2003)	Discourse Analysis	OSCE data	Avoidance of certain communicative strategies. Importance of a 'crux' also discussed.

Sonnex (2008)	n/a	Theoretical	Emphasis on patient-centeredness; do not discourage patient from expressing emotions.
Suchman (1997)	Quasi-Grounded Theory	Audio-visual recordings of doctor-patient interaction	Importance of empathic opportunities discussed, which stress the need to elicit emotions from patients.
Wynn (2005)	Conversation Analysis	Corpus data	Empathy expressed in four ways: cognitive, affective, sharing and nurturant.

4.2. DISCUSSION OF SEARCH RESULTS

The literature search identified a total of ten studies, shown in Table 3. Four studies utilised conversation analysis, one discourse analysis, two grounded theory, one phenomenology and two theoretical data. The primary findings and conclusions from the papers are detailed, and these are then critiqued with regard to methodological issues and analytical procedures in order to define any gaps in the literature, and thus understand how this thesis can best contribute to the existing knowledge in the field.

4.2.1. Expressions of Empathy

From the papers acquired through the search strategy, there were a range of findings related to how empathy is expressed in medical consultations. Cordella and Musgrave (2009) drew three primary conclusions surrounding the expression of empathy in their paper. Firstly, they discussed the role of sequential organisation, where three general strategies were utilised by candidates in the expression/omission of empathy: (a) candidates initiate a sequence of positive reassurance following bad news delivery (b) patients request further reassurance following candidates' reassurance sequence (c) candidates deliver the bad news and do not initiate sequence of positive reassurance. In addition to this, the authors explored emotionally charged lexical items, where the choice of lexis used to refer to the disease and adoption of others' lexical items was deemed a form of empathetic process. Turn taking was also considered in relation to empathy, with the length of pauses being highlighted as having a potential impact on empathetic expression. It was also noted that transition relevance points (where the floor would switch from one participant to the other) were sometimes missed in the consultation, and this led to a breakdown in communication and hence empathetic rapport.

Similarly to Cordella and Musgrave, Wynn (2005) also focused on sequences of empathetic understanding, and found four types of empathetic expression in his data, pertaining to Bachelor's (1988) categories: cognitive, affective, sharing and nurturant empathy. Cognitive empathy was the term used to refer to interactions

where a physician would recognise what a patient was feeling, and then verbalise this feeling. Similarly, the affective component of empathy was found to involve a physician partaking of the same moment as the patient. Sharing empathy was a technique used where commonality between doctor and patient was emphasised, and this was augmented with nurturant empathy, where the doctor was supportive and attentive to the patient's needs. Martinovski et al. (2007) found a similar strategy for expressing empathy, which they classified as 'parallel' empathy, and involved exclamations of others' expressions of emotions, rhetorical questions and assessments. Moreover, they noted more general empathetic strategies may be used, such as questions, tags, mitigation strategies and cooperation strategies. Finally, with regard to the expression of empathy, they defined reactive empathy as consisting of statements about others' mental states.

Roberts et al.'s (2003) research unveiled a number of strategies used in the expression of empathy within undergraduate medical education examinations. Rather than techniques used to express empathy, many of the conclusions drawn from this research were concerned with what the medical students should avoid doing in a consultation to avoid a breakdown in empathetic communication. These included a schema driven progression of the consultation and patient labelling, where each simulated patient was treated in a generic manner depending on the problem they had, with little or no consideration going towards the effect the problem was having on the individual themselves. Furthermore, an inability to judge how much the simulated patient understood was also an issue here, with jargon, assumptions about the patient and negative labelling all being linguistic devices used which detracted from establishing rapport and expressing empathy. In addition, their results emphasised the importance of attentive listening, where the medical student responded appropriately, taking into consideration the information they had already obtained from the simulated patient; Roberts et al. (2003: 197) claimed that there was a 'storage failure' when the medical student failed to recall a key fact from earlier in the consultation. One of the more proactive techniques that could be utilised included joint problem solving with the patient (similar to the concept of shared decision making), which involved the frequent use of the first person plural pronoun 'we'. Finally, the importance of a 'crux' was highlighted in the thematic

staging of the consultation: a point around which the interaction was organised and led up to, and the role this played in the development of empathy.

The use of tag questions in consultations were the primary focus of Harres' (1998) paper, with the main conclusions being that they are used both as a method for the doctor to manage the agenda, and at the same time allowing them to connect with the patient. Tag questions were deemed to have the effect of opening the consultation to the patient, so that any ideas, concerns or expectations may be elicited to a greater extent. Affective tag questions were discussed and these were vital in the expression of empathy, acknowledging the patients' experience and applying shared knowledge in the consultation. Similarly to Roberts et al.'s (2003) research, Harres emphasised the role that the word 'we' played in applying this shared knowledge.

Both Norfolk et al.'s (2007) paper and Suchman et al.'s (1997) paper attempted to create a model of how empathy was realised in the consultation. Norfolk et al.'s model comprised of the role that empathy played in building rapport. They listed empathic motivation as being the initial stage in the model, where the physician would have the desire to understand the patient's perspective, and this then moved to empathic attention, where the doctor would look for cues and clues from the patient so as to assess their thoughts and feelings as the consultation progressed. Next the doctor's empathic skills were required to interpret these cues and clues and this information was then utilised by the doctor to elicit further information from the patient, thus gaining a more detailed understanding of the patient's perspective.

Suchman et al.'s model differed from Norfolk's in the sense that it was more concerned with detailing the interactional sequence involved in empathetic understanding. The emphasis with this model was on empathetic opportunities, and how a doctor must create the right circumstances to use empathic responses. The model began with what was termed a 'potential empathic opportunity', which then required the doctor to produce a 'continuer' in order to gain the chance to express empathy and make the patient feel understood. Like Roberts et al.'s (2003) paper, there was also an emphasis on the doctor avoiding certain communicative acts, which would otherwise have terminated the chance for empathy to be expressed.

Morse et al. (2008) expanded upon Suchman et al.'s work by examining missed empathetic opportunities for interval empathy in lung cancer communication, where interval empathy refers to the provision of empathetic responses throughout the consultation. Their key finding was that physicians rarely responded in an empathetic manner to the patient's concerns, with only 39% of 384 empathetic opportunities being responded to in such a manner. Moreover, they also note that the majority of empathetic statements occurred in the final third of the consultation. However, the actual communicative act of the empathetic response was not defined within the paper.

The final two papers examined here contained theoretical data (i.e., the findings from the papers were not a result of direct scientific enquiry, but based on the observations and experiences of the authors), but still contributed to the field of knowledge, albeit from an individual perspective. Coulehan's (2001) paper focused on words that help to build empathy, with one of the key sections of the paper discussing the identification and calibration of emotion, and how this was expressed in the consultation through varying lexical choice. Alternatively, Sonnex (2008) emphasised the need for patient centeredness, and alluded to Suchman et al.'s model (1997) as a method of achieving this. He also foregrounded the need for doctors to not discourage patients from expressing their thoughts and feelings, and to consider not just the physical symptoms, but how they are impacting on the patient on an individual level.

4.2.2. Identification of Empathy

The main issue with all the included papers was the method used for identifying where empathy was present. As previously stated, 'empathy' is an abstract noun, and as such, opinions of what exactly empathy constitutes may be mixed within the research community. This was highlighted with the chasm of difference relating to how many instances of empathy each researcher found in their respective papers. For example, one paper claimed that there were 16 occurrences of sequences involving empathy in 77 consultations (Wynn, 2005: 165), whereas another paper deemed empathic sequences to be present in eight out of 11 consultations (Cordella and

Musgrave, 2009: 131), hence being much more frequent. This could have been due to the data under examination; however, it would appear more likely that it was a result of differing definitions of empathy.

The most frequent method used for deciphering what was classified as empathy was using predetermined definitions. Cordella and Musgrave utilised the definition 'a shift in perspective away from our own to an acknowledgement of the other person's different experience' (Bennett, 1979: 417) to classify what parts of the corpus were deemed empathetic. Similarly, Wynn drew upon categorisations which stemmed from Bachelor's work in psychotherapy (Bachelor, 1988), where a content analysis suggested that empathy was divided into four sub-categories: cognitive, affective, sharing and nurturant. This highlighted the difficulties posed not just in the study of empathy, but also the decisions concerning where empathy was present in interaction: both papers used similar methods to decide where empathy was present, but what was actually deemed to be an empathetic act varied based upon the researcher's own interpretation of definitions and also the amount of definitions available. Wynn did note this was a limitation of the project, claiming that 'it is possible that there were sequences that were not categorised as empathetic, but that could have been so if other systems of categorisation had been applied' (Wynn, 2005: 166). Again, this echoes the idea that defining where empathy was present in interaction is a multi-faceted and arduous task, and may account for why the classification of empathetic acts in both Cordella and Musgrave's and Wynn's respective papers varied so greatly.

Martinovski et al. (2007) approached their data in a similar fashion; however, they did not explicitly state how it was decided that empathy was present in the data. They listed various definitions of empathy, but there was no critical examination of what empathy was, or – more importantly – how it was decided that it was present in certain parts of the corpus. Therefore, it would appear that utilising predetermined definitions of empathy was problematic. The accuracy of the definitions was questionable, in that the process of defining empathy was essentially the articulation of a cognitive mechanism; thus the levels to which language could accurately capture what empathy was were unknown. Moreover, the individual personal experience of

the person defining the concept of empathy may have shaped or contributed to what they deemed empathy to be, again affecting the definition. Finally, the impact that the researchers who applied these definitions have must be taken into consideration, as different researchers may interpret the same definition in a different way, and thus apply it to the data differently.

The dilemma of interpreting what was deemed to be empathetic was overcome to an extent in Roberts et al.'s (2003) paper. Here, the basis for the assessment of empathy was conducted via the OSCE (objective structured clinical exams) marking system, which was designed to account for variation between assessors' opinions on what good communication skills constitute. The assumption made here was that good communication is synonymous with the use of empathy, and, while this seems logical, the OSCE marking system for consultation skills consists of many other factors involved in communication, meaning that it would be theoretically possible to score highly for the marks relating to consultation skills, but show little or no empathy. A similar, yet alternative, approach to deciphering where empathy was present came from Suchman et al. (1997). Here, the researchers used a methodology similar to a type of grounded theory, and, rather than using predetermined definitions of empathy, each member of the research team (n=4) openly coded the data based on where they deemed empathy to be present. This was then triangulated and the data were pulled together. Where more than one researcher had deemed a part of the data to involve some form of empathetic content, it increased the likelihood that that part of the interaction was indeed an act of empathy, thus enhancing the reliability of the interpretation. This was still, however, only conducted from the researchers' perspectives, thus not taking into account the patient perspective on the data and interpretation. This technique was extended by Morse et al. (2008), who – in addition to using three researchers to code the data – also attempted to verify their results with a key patient informant post-coding. However, the patient role was to verify the coding done by the researchers, rather than assist with it, which may have limited the range of codes produced.

An inductive approach could also be seen to an extent in Norfolk et al.'s paper (2007). Here, a hypothetical model of how empathy works in medical consultations

was created based upon previous research in the psychological and medical fields. This model was then tested using semi-structured interviews, gaining opinions on the model from fellow clinicians, and amending it accordingly. One of the problems here was that the model was derived from theoretical data, and this was also the case with Sonnex (2008) and Coulehan's (2001) papers, where models of empathetic communication were fashioned from their own knowledge of empathy usage in the medical practice. While this was useful in helping to understand empathy from the perspective of the clinician, it was only examining empathy from a very specific and ultimately biased viewpoint. Hence this foregrounds the need for more applicable models of empathy to be derived from data.

With regard to the defining of empathy in the papers, it could be argued that the research falls into two main categories: there are the papers which take a deductive approach, with the use of predetermined definitions of empathy (Martinovski et al., 2007, Wynn, 2005, Cordella and Musgrave, 2009) and those which build their definitions of empathy inductively (Norfolk et al., 2007, Suchman et al., 1997). Arguably, the research from Roberts et al. (2003) attempts to combine this, but the choice of OSCE data posed problems regarding whether the paper was actually assessing empathy, or general communication. Hence it would appear that an inductive approach to examining multiple perspectives of expressions of empathy would contribute considerably to the current knowledge and research on the topic.

4.2.3. Approaches

It is useful to examine in more detail the approach that each of the papers took with regard to their overall methodology and analytical approach. Discourse/Conversation analytic methods were applied in five of the papers. Cordella and Musgrave's (2009) paper utilised a form of discourse analysis examining sequential organisation, emotionally charged lexical items and turn-taking. This was similar to the approaches taken by both Wynn (2005) and Martinovski et al. (2007), who both employed a form of conversation analysis. While Wynn also examined sequential organisation with regard to Bachelor's (1988) categorisations of empathy, Martinovski et al.'s focus was on how empathetic statements could be accepted or

rejected in a polite or antagonistic manner. Furthermore, Harres' (1998) paper examined how empathy was expressed through the use of tag questions. While these papers all contributed to the understanding of empathetic communication, their deductive approach led them all to make the same assumption: that empathy was expressed verbally through the use of language. The papers predominantly overlooked the use of non-verbal behaviour, preferring instead to focus upon the linguistic aspects of communication. In theory, empathy may not be expressed through language at all, and, if it is, then the extent to which non-verbal behaviour impacts upon empathetic communication must be taken into account.

Those papers which did examine the data with a more inductive approach failed to account for both the non-verbal aspects of communication, and to a large extent, the inherent meanings in the language. This was apparent in Norfolk et al.'s (2007) paper, where the model created seemed to be more concerned with the macro aspect of consultations, rather than the micro; that is to say the model explained *what* was happening in the consultation, rather than *how* it was happening. For example, in the 'Empathic Motivation' section of the model, Norfolk et al. listed 'warmth (caring)' (Norfolk et al., 2007: 695) as a mechanism by which empathetic communication is achieved; however, it does not say how this is realised through the use of language or non-verbal behaviour. Moreover, Suchman et al.'s model examined the micro elements of the consultation to a greater extent, and drew on these parts to build toward a macro model of empathy. However, it still did not account for the non-verbal aspects and how these interacted with the language used to create specific meanings. This was also acknowledged by Morse et al. (2008), who noted the absence of non-verbal examination due to the type of data used.

4.2.4. Data Quality

There was a range of data sources from which the findings of these papers were derived. As previously stated, both Sonnex (2008) and Coulehan's (2001) papers obtained their conclusions about how empathy was expressed from theory. Both of these authors were medical doctors, and thus it is logical to assume that their theoretical data stems from their own experiences of empathy in the medical

practice. Whilst this does not necessarily make the data trustworthy in terms of an overall theory of empathy, it does contribute to what is deemed to be an empathetic act from the perspective of the doctor, although the conclusions must be viewed as such: not being considered a universal theory of empathy expression.

Another data source which was employed stemmed from corpora. Wynn (2005) obtained data from the British National Corpus (BNC) which involved interactions between doctors and patients. This posed a number of issues regarding the quality of the data. Firstly, the BNC is notoriously slow to update, due to the sheer magnitude of data that needs to be entered into it on a regular basis. Hence it is not unreasonable to assume that the data being used by Wynn here comes from before 1993, when consultation skills were not formally taught in medical education. Therefore the findings from Wynn's conversation analysis may differ greatly in comparison to findings obtained from more recent data, where models of medical consultations such as the Cambridge-Calgary guide have been used to train the subjects being researched. Moreover, another issue with using corpora is that the data obtained is usually secondary or tertiary. In order for the data to be placed into the corpus, the doctor patient interviews would first have had to have been conducted and recorded, then transcribed to be loaded into the corpus, thus potentially losing essential elements of the data concerning the non-verbal behaviour, subtle linguistic devices and the meanings conveyed. In addition, corpora limit the researcher's ability to ascertain detailed information on the subjects being studied and the setting in which the consultations took place, thus decreasing the transferability of the data.

A similar issue arose with the data used in Martinovski et al.'s (2007) research. They drew upon data collected from the TalkBank research project (a type of corpus) which meant that the same issues that applied to Wynn's data could also have been prevalent here. However, in addition to this, they also used 'Role Play and friends' talk' (Martinovski et al., 2007: 63) which was data collected by the team of researchers [4]. The data appeared to have been selected specifically to show how

[4] Confirmed via e-mail: 28/02/2013.

empathy was accepted in one case and rejected in others. Whilst this was a legitimate method of examining how empathy was responded to, it did not give any indication as to how frequently these strategies were employed, and thus whether the data were an accurate representation of the true nature of the rejection of empathy.

Regarding the research from Cordella and Musgrave (2009), they claimed that 'the data we consider here was taken from a training session for IMGs (International Medical Graduates) preparing for the actual Australian Medical Council examination' (Cordella and Musgrave, 2009: 129). The data were compiled into a corpus and had been collected by the authors themselves[5]. It was stated that the data collected consisted of the IMG role-playing a consultation scenario with a medical practitioner playing the patient; hence the participants were already qualified doctors preparing for an important assessment to enable them to practice in Australia. This method of data collection was also utilised by Roberts et al. (2003), whose data were taken directly from OSCEs. It could be argued that these methods of data collection are more reliable than using previously compiled corpus data, as the researchers have the original recordings of the examinations and can transcribe these themselves, thus increasing the accuracy and reliability of the dataset. However, it must also be considered that examinations and OSCEs are pressured scenarios in which the students are expected to blend advanced medical knowledge into a logical and well-constructed consultation, and this pressure may affect the way in which students behave and attempt to express empathy.

Alternative data types were apparent in other papers (Harres, 1998, Suchman et al., 1997, Morse et al., 2008), which examined real life consultations, as opposed to simulated ones. Harres' (1998) research looked at audio-recordings of interactions between three female GPs and their patients. The choice of audio recording as opposed to video recording meant that the gesticular aspect of the consultation was omitted, but also, it was unclear as to why only female GPs' consultations were examined; it is assumed that this may be a convenience sample, but this is not

[5] Thanks go to Prof. Peter Campion for contacting the authors to confirm this.

explicitly stated in the paper. Moreover, the issue of whether consultations differed depending on whether they were conducted by a male or female practitioner was not considered, but rather assumed.

In Suchman et al.'s paper, it was stated that the initial data were selected from 'primary care office visits chosen at random from our files and videotape library' with supplementary data coming from '5 videotapes of primary care visits to 3 faculty internists with expertise in medical interviewing and psychosocial medicine' (Suchman et al., 1997: 679). Thus it was unclear from this description whether the data used was actually authentic data. Transcripts of lung cancer consultations were used by Morse et al. (2008). It is unclear whether the transcripts of the recordings were produced by the researchers, and, if not, it must be considered that some aspects of the consultations may have been lost or misinterpreted. The data came from a larger observational study of 137 patients, and were selected by the researchers using a convenience sample, with an emphasis on equal numbers of black and white patients, and only male patients being included in the sample.

The final type of data considered also involved GPs, but rather than examining their performance in a consultation, Norfolk et al.'s (2007) paper drew upon the experiences and ideas about what empathy consisted of in a medical consultation to test a hypothetical model of empathy. The paper also utilised data collected from clinical psychologists, giving a broader view of how empathy may be expressed in consultation, but potentially skewing the data to conform to a slightly different mode of consultation. The data were collected through 90 minute semi-structured interviews, in which the participants were required to describe their experiences of what rapport was, and examples from their own practice as to where rapport had been built well and proved difficult to establish. This enhanced the accuracy of the data, as the opinions given were not concerned with the model being tested initially, but rather the personal experiences of the professionals being interviewed. Moreover, the participants were asked to conclude the interview by commenting on the validity of the model, again improving the accuracy of the model.

4.2.5. Trustworthiness of Conclusions

The implementation of established methodological procedures increased the trustworthiness of the conclusions drawn from the papers, and this was apparent in the papers which utilised conversation analysis and discourse analysis. Wynn (2005), and Martinovski et al.'s (2007) use of conversation analysis enhanced the transferability of their research. This increased the transparency of the procedure, allowed others to judge the data, and make informed decisions for themselves about the credibility of the conclusions drawn in the papers. However, it must be remembered that the data were only as accurate as the transcripts would allow, and also that what was provided in the papers was only a small portion of the overall data collected in each case. Moreover, it was unclear the extent to which imposing a conversation analysis framework here impacted upon the conclusions.

This was further apparent in Harres' (1998) paper, where conversation analysis was used, but there was a focus on the research topic of tag questions. While this specificity allowed for rich descriptions of how empathy was expressed through the medium, it did not take into account other ways in which it is expressed. Moreover, the fact Harres identified 90 tag questions, but provided transcripts of only a few examples decreased the transferability of the data (although it is likely that this is due to the restrictions on word limit in the journal the article was published in). The most reliable discourse/conversation analysis approach came from Roberts et al. (2003). Although a deductive approach was employed here – with work by Tannen (1989) being the basis for analysing the data – the analysis maintained some level of inductive processing due to the use of the OSCE mark system, which was designed to take into account all of the examiners' views on good and bad consultations. Hence this appeared to merge deductive and inductive approaches to defining empathy, in the process enhancing the confirmability of the analysis.

Other research (Suchman et al., 1997, Morse et al., 2008) made use of aspects of grounded theory. Suchman et al. (1997) approached the data having not consulted previous literature, thus mitigating preconceived ideas being imposed upon the data and avoiding potential bias. The main issue with this approach to the data was that

the researcher could not be sure if the experiment has been conducted before, and thus it was unknown the levels to which the research would add to the existing body of knowledge. However, this was overcome to an extent in the paper by comparing the results obtained to previous research *after* the analysis has been conducted. This way, the analysis was not influenced by previous research categories or results, but still managed to position itself within an existing knowledge framework. Moreover, to further enhance the credibility of the analysis, the authors all coded the data individually, then brought the individual analyses together, which paralleled grounded theory's open and axial coding stages (Charmaz, 2006) and acted as a form of triangulating the data. However, one way in which the methodology did not follow grounded theory in the classical usage of the term was that the paper was unclear on the levels of theoretical saturation. It did acknowledge that two different samples were used (one audio, the other audio-visual), but it was ultimately a convenience sample, rather than a theoretical one. Morse et al. (2008) adopted a similar approach, but stated that theoretical saturation was reached with the analysis. The fact that the data were also taken to a patient informant further supports the findings, although the input the informant had is not detailed in great depth, other than to say that the spiritual aspect of empathy was added into their findings as a result of the verification.

Norfolk et al. (2007) processed the data from a similar angle, in that the participants in the study were asked to describe their own opinions pertaining to definitions of rapport, and give examples drawn from their experiences of consultations which had gone well or been more difficult, hence mirroring an inductive approach. However, it was claimed as a limitation of the paper that 'most of the GPs had some knowledge of the model prior to the interview because of their role in previous training activities' (Norfolk et al., 2007), thus potentially influencing their own opinions of what empathy constituted, and agreeing to a greater extent with the components of the model. It appeared that conversation analysis and discourse analysis were popular methods of examining how empathy was expressed; however, these were predominantly conducted deductively, thus making assumptions about how empathy worked in communication. Those papers which did take a more grounded, inductive approach were less concerned with the language on a micro scale, and more about

the consultation as a whole. None of the papers examined the data using a sociolinguistic framework while employing inductive methods.

It is anomalous that given empathy's subjective nature, few of the papers accounted for the patient's perspective on the data, and this was particularly apparent in those papers which utilised data extracted from pre-existing corpora. The lack of feedback was not just missing from studies using corpora; Harres' paper, which used authentic data, also did not consider how empathy was expressed from the patient's perspective, as did Suchman et al. (1997) and Norfolk et al. (2007); however, Norfolk et al. did acknowledge that this is due to the scope of the paper, and considered it an area for future research. The only paper which did seem to take into account the patient perspective was Roberts et al.'s (2003), although this is still limited to the perspective of the actor playing the patient, rather than a genuine patient view.

There were a number of instances in the papers where the authors claimed negative data were apparent in the findings. One of the most salient of these came from Norfolk et al.'s (2007), where, as a result of a negative case, the theoretical model was revised accordingly to include the concept of 'empathetic attention', and, although this complemented, rather than opposed the model, it was still an example of how the authors acknowledged a negative case in the data, and revised a theory accordingly. Cordella and Musgrave (2009), also found a negative case in their data, which involved the omission of the lexical item 'tumour' from only one of the consultations examined. They concluded that this was due to the patient pre-empting the usage of the word by acknowledging there was bad news to come, and the physician empathised and understood this from the patient's perspective, refraining from using the word throughout the rest of the consultation in order to avoid further upset. Moreover, Martinovski et al.'s (2007) research could also be deemed to contain negative cases, in that they acknowledged the distinction between empathy being accepted and rejected, although it did appear that the data were used to fit this distinction, rather than the negative case emerging from the data. The other papers, particularly those involved with a form of conversation analysis or discourse analysis, did not return any obvious negative cases, and this was most likely due to

their deductive approach, where they were looking for specific linguistic devices, rather than letting the findings emerge from the data.

4.2.6. Gaps in the Literature

This appraisal of the literature has revealed the gaps in the existing body of knowledge, and also some of the potential issues arising when studying how empathy is expressed. Most notably, what empathy is and how it is defined has been discussed, with the approaches ranging from using predetermined definitions to the researchers' own opinions on what empathy constitutes. Remembering that empathy is an abstract noun, and that different people's definitions of it vary – Suchman et al's inductive approach involving the coding of empathy by various researchers, and then bringing these opinions together – seemed a reliable method of deciphering where empathy was present, and it would be useful to apply this within a sociolinguistic framework. However, the papers which did approach the data from an inductive perspective failed to provide an in-depth analysis of the interaction on a micro scale, instead choosing to focus on the overall construction and development of empathy in consultations.

Conversely, the papers which took a deductive approach concentrated too narrowly on specific aspects of the consultation, with little consideration as to whether empathy was truly being expressed, hence supporting the need for research to be conducted involving an inductive sociolinguistic analysis of empathy expression. The various methodological approaches that the papers took to study how empathy was expressed have been discussed, with one of the primary conclusions being that none of the papers considered non-verbal behaviour, particularly gesticulation. There was a wide variety of data utilised by the researchers, and these ranged from using theoretical data, to simulated data from corpora or OSCEs, to data taken from genuine consultations. Issues with the pressure medical students are put under in OSCEs have been considered, and the affect this may have on their empathetic performance noted. The limits of data taken from corpora have also been examined.

Finally, the trustworthiness of the conclusions were considered, with the roles that established methodological procedures, patient perspective on the data, and negative data may play in the analysis being raised. From this appraisal of the literature, a clear gap has emerged in the existing body of knowledge, with a need for research to be conducted using a sociolinguistic framework augmented by an inductive approach to decipher not just how empathy is expressed in medical consultations, but where. In conclusion, this review has informed the methodological procedure of the project, which is the focus of the next chapter.

SECTION TWO

CHAPTER FIVE: METHODOLOGY

5.0. INTRODUCTION

Chapter Two gave an overview of the thesis, and background pertaining to communication and empathy in general. Chapters Three and Four discussed the literature in more detail, and showed a gap in the literature relating to the coding of empathy being predominantly conducted deductively by the researcher. This chapter begins by formulating the research questions which emerged from this, with the aims and objectives of the thesis being set out. A conceptual framework for addressing these aims and objectives is then discussed and the methodological tools utilised from grounded theory and sociolinguistics detailed.

5.1. RESEARCH QUESTIONS

The main aim of this research was to explore how empathy is perceived to be expressed by different people in the field of medical education. Since the introduction of more formalised consultation skills training in undergraduate medical education (GMC, 1993), a wealth of interest has developed within academia. Previous work has focused on measuring empathy (Hemmerdinger et al., 2007, Pedersen, 2009, Satterfield and Ellen, 2007), but usually considers empathy from one perspective: the researcher's. There is still debate as to what empathy is, how it is expressed, and even if it is a phenomenon which can be studied (Davis, 1990). The aims of this thesis are therefore:

- To explore the perceptions of undergraduate consultation skills training and assessment members at the University of East Anglia relating to how empathy is expressed.
- To build a model of empathetic expressions through the examination of behavioural correlates in simulated consultations.

- To explicate this framework and examine the linguistic and non-verbal features of interaction which co-occur with perceived expressions of empathy.

By exploring perceptions of empathy, rather than attempting to study empathy itself, this research ensured that it was studying something which could be analysed and discussed. The main groups involved in the study were the medical students themselves, role-players who have played the role of simulated patients during the consultation skills training and assessment at the UEA, and also myself, in a multi-faceted role as a researcher/consultation skills tutor (reflections on this role are elaborated upon in more depth in Chapter Six). Through the involvement of those in medical education, the study is paralleling the current methods of teaching and examination.

Within these aims, there was a set of objectives which had implications in terms of teaching, assessment and recruitment of medical students, as well as broader implications to the overall structure and delivery of consultations in the medical profession. Therefore, the objectives were to better understand:

- How empathy is deemed to be expressed through language.
- The role cooperation plays in the expression of empathy.
- How politeness influences the expression of empathy.
- How the findings can be applied to medical education and/or clinical practice.
- If perceptions of empathy differ between those in the field of medical education.
- If perceptions of empathy do differ, then what effect this has on medical students' consultation skills training and assessment.
- The role non-verbal behaviour plays in augmenting the expression of empathy.
- The role gesticulation plays in augmenting the expression of empathy.
- Other factors which contribute to the expression of empathy.

To summarise, the methodological approach taken in this thesis aims to explore the concept of empathy, and how different people involved in medical education and assessment interpret it in different ways. From this, suggestions are made on how to augment and improve the way in which consultation skills training is delivered in medical education, particularly at the UEA.

5.2. CONCEPTUAL FRAMEWORK

5.2.1. Ontological Considerations

Ontology may be defined as 'the theory of being... what does exist and what is the nature of existential entities' (Gomm, 2009: 114). It is often divided into two main categories: objectivism and constuctionism (Bryman, 2008: 18-20). Objectivism takes the stance that 'the investigator and the investigated object are assumed to be independent entities, and the investigator to be capable of studying the object without influencing it or being influenced by it' (Guba and Lincoln, 1994: 110). That is to say that the universe exists regardless of societal stimuli. In contrast to this, constuctionism relates to 'the goal of understanding the complex world of lived experience from the point of view of those who live it' (Schwandt, 1994: 118). Vivian Burr delineates this further, to talk about social constuctionism. She confesses that there is no single definition of social constuctionism, but that at its foundation, it incorporates one or more of the following features (Burr, 1995: 3-5):

- A critical stance towards taken-for-granted knowledge.
- Historical and cultural specificity.
- Knowledge is sustained by social processes.
- Knowledge and social action go together.

The approach taken in this research overlaps with all of these points. A critical stance on taken-for-granted knowledge is taken concerning what empathy is, and how people may interpret its expression differently. Moreover, empathy is treated as a culturally specific phenomenon. The scope of this thesis only examines empathy in

medical education and more importantly, only in the English language. It has been hypothesised that language can determine thought, and limit cognitive categories (Hoijer, 1994), thus indicating empathy may be deemed to be culturally and linguistically specific. In addition to this Burr notes that knowledge of the social world is constructed between them, and sustained by social process. Thus empathy may be seen to be an ever evolving and changing concept, and that these numerous possible constructions of 'empathy' can be seen from many angles, this just being one of them. Therefore, due to the nature of examining an abstract concept such as empathy, this research adopts a social constuctionism perspective. It makes the assumption that human beings have at least some impact upon society, especially with regard to abstract concepts, which require a degree of agreement amongst people to function. If one person's view of empathy deviates significantly from another, then any expressions of empathy to the other may not be received in the intended manner. Thus, expressions of empathy require at least two or more interlocutors to work, and thus require the concept to be constructed socially in order to be comprehensible

5.2.2. Epistemological Considerations

Having discussed empathy as an ontological entity, the epistemological perspective from which this research was conducted must be considered. Epistemology is concerned with the theory of knowledge; how we can gain knowledge, and how we know that the knowledge gained is true (Gomm, 2009: 114). Corbetta (2003: 13-24) lists some of the predominant epistemological positions, which range from positivism through post positivism to interpretivism.

Positivism is closely linked with objectivism, and is widely used in the natural sciences. It treats social reality as knowable: that there is a single truth to discover which is not influenced by social or contextual factors. The Positivist paradigm argues that knowledge can be obtained in an objective and unbiased way, through measurement, empirical verification and other, more quantitative based, methods. It appears that this is not the case with regard to the concept of empathy. Previous research has tended to focus on the assessment and measurement of empathy, and a

number of literature reviews have put heavy emphasis on quantitative methodologies when examining the concept (Hemmerdinger et al., 2007, Pedersen, 2009, Satterfield and Ellen, 2007). Given empathy's subjective nature, it could be argued that assigning numbers to an abstract concept is not the best encompassing method of assessment. While quantitative studies can show levels of empathy and shifts in empathic attitudes, they cannot account for the process through which empathy is communicated and expressed.

Conversely, interpretivism takes a divergent view to that of the positivist paradigm. Stemming from the work of Max Weber (Weber, 1947), interpretivists consider the study of the social world is very different from the study of the scientific world (Bryman, 2008: 14). They propose that in order to study the social world, a different logic is required; one which embraces, rather than attempts to nullify, the influence that people and institutions may have. This is encapsulated by Piergiorgio Corbetta, who claims that 'by treating social reality and human action as something that could be studied objectively, the positivist approach overlooked the individual dimension: all those aspects that distinguish the world of human beings from the world of things' (Corbetta, 2003: 23). Therefore, interpretivism takes the view that society is not constant, but fluid and ever-changing as a result of the actions of individuals, who subsequently become an integral part of the research process. Evidently this approach is much more subjective than the positivist persuasion, and as such, the researcher must be more reflexive and aware of the role they are playing in the research process (this is discussed in relation to this project in Chapter Six).

The epistemological approach adopted in this research is more akin to interpretivism. The methodological tools utilised are sensitive to studying the world from changing perspectives and considering how individuals in medical education impact and influence the concept of empathy within the field. Rather than being avoided, this influence has been built into the methodology, through the use of member coding, to embrace these different perspectives. This thesis adopts the approach that empathy is not one thing, but that it has to be agreed upon *to some extent* for society to understand and employ it. If not, then it would make the selection and teaching of medical students even more problematic than it already is. This research offers an

interpretation of how empathy is deemed to be expressed in medical education from a number of perspectives, each with their own position and attitude to the field of medical education.

5.3. METHODOLOGICAL TOOLS

The design of this study is split into two main sections, with the first section utilising tools from aspects of grounded theory, and the second from sociolinguistics. Firstly, a framework of perceived empathetic expressions was inductively generated through tools adapted from grounded theory (Glazer and Strauss, 1967). The study did not follow the methodological rigidity of grounded theory, but incorporated and adapted aspects of it. Therefore, it could be claimed that the study was using a quasi-grounded theory approach. Once this framework was in place, the behavioural correlates of perceived empathetic expressions were then analysed through tools adapted from the fields of Conversation Analysis and pragmatics, such as detailed transcriptions (Jefferson, 2004), the sequential organisation of the conversation (Sacks et al., 1974), and theories of politeness and cooperation (Brown and Levinson, 1987, Grice, 1975). To a lesser extent, the study was also ethnographic, as during the project, the researcher was also teaching consultation skills in the UEA medical school. Therefore, some of these experiences are built into the analysis where relevant.

5.3.1. Grounded Theory

Grounded theory was a term coined by sociologists Anselm Strauss and Barney Glazer (Glazer and Strauss, 1967), to describe a systematic methodological approach they took to research. It is based on the idea of inductive theory generation, where, instead of starting with a hypothesis, the first stage of research is data collection (Charmaz, 2004: 497). From the data, codes are created and then rigorously compared and contrasted, allowing themes to emerge and ultimately create theory. Note that although this is an established method in itself, this project adopts a quasi-grounded theory approach, which draws upon, but does not rigorously follow, the processes involved in the method.

Grounded theory is underpinned by symbolic interactionism, which pertains to the idea that 'meaning is socially constructed, negotiated and changes over time' (Morse, 1994: 39), and this relates to the concept of empathy as a socially constructed concept. As previously mentioned, the word 'empathy' is an abstract noun, meaning that its comprehension is dependent on social agreement between two or more parties at any one time (Spiro et al., 1996: 5). However, the majority of the literature examining how empathy is expressed in medical practice approaches it from an exclusive perspective (that of the researcher), and therefore this may lead to narrow – or even inaccurate – interpretations of the concept. To overcome this, this study uses an adaptation of grounded theory which involves the participants' as well as researcher's perspective on empathetic expressions. Not only does this provide additional perspectives, but also parallels the current assessment of empathy in medical education, where both the role-players and consultation skills tutors award marks in the OCSEs. The traditional grounded theory method has been adapted by academics in a number of cases. For example, researchers have attempted to merge phenomenology and grounded theory (Wilson and Hutchinson, 1991, Baker et al., 1992). Another study introduces dimensional analysis as an alternative to replace the rigid coding system (Schatzman, 1991). Whereas traditional grounded theory provides a stringent set of guidelines, ranging from the collection of data to the creation of theory, this project deviates from this, and the procedure and rationale for doing so is discussed in the following sections.

Use of the literature

As previously discussed, the process of grounded theory traditionally begins with the collection of data (Charmaz, 2004: 497). It has been argued that by doing this instead of consulting the literature, the potential influence of pre-conceptualisation of the data by the researcher can be mitigated, as the literature is not impacting upon the researcher, whether consciously or sub-consciously (Hickey, 1997, Stern, 1980, Strauss and Corbin, 1994, Lincoln and Guba, 1985). The obvious deficiency with this approach is summarised by Cutcliffe (2000), who claims that 'no potential researcher is an empty vessel, a person with no history or background. Further, as it

is common for many researchers to pursue a particular theme throughout their research activity, they may already possess some background knowledge of the substantive area they intend to study. Indeed, the researcher and all his/her knowledge and prior experience is bound up with the interactive processes of data collection and analysis' (Cutcliffe, 2000: 1480). Moreover, Denscombe (2003) pointed out that by ignoring the literature surrounding a topic, there is a danger that the findings may ignore the influence of social, economic, political and historical factors, which could be crucial in the creation of a holistic theory. This has parallels with other research in the field, which makes the assumption that empathy is expressed in sequences as a result of the researcher's conversation analytic background (Martinovski et al., 2007, Wynn, 2005, Cordella and Musgrave, 2009). However, it must be considered that empathy may be deemed to be expressed in different ways by different people, thus highlighting the importance of the inductive approach that grounded theory can provide.

A researcher who is involved closely with his or her field might already be acquainted with the literature on the topic. However, if the research is reflexive throughout the research process, then this should not prevent a grounded theory developing (McGhee et al., 2007). Some researchers suggest that grounded theory should incorporate two literature reviews in relation to the research. In the first instance literature used can provide only sensitising concepts and an awareness of gaps in the knowledge. Once data has been collected and the concepts, constructs and properties formed however, a second literature review can link these to the extant research and theory (Hutchinson and Wilson, 1993: 233). The main difficulty with this is that without consulting the literature thoroughly, it is unlikely that the researcher will know what work has already been conducted in the field, or what work needs doing to build on this. It could be argued that a review of the literature surrounding a topic at an early stage is vital in the conceptualisation and planning of research. This point is supported by Charmaz (2006), who claims that 'completing a thorough, sharply focused literature review strengthens your argument – and your credibility' (Charmaz, 2006: 166). She also notes the difficulties when applying for research or grant proposals, and their demand for sophisticated knowledge of the research conducted in the field already. Her solution to this dilemma is a

compromise: 'to use [the literature] without letting it stifle your creativity or strangle your theory' (Charmaz, 2006: 166), and this echoes the importance of reflexivity as an indispensable process in this research.

In light of the above arguments, this research did consult the literature before any data were collected; however, the pre-conceptualisation was overcome to an extent by triangulating participants' perspectives of empathetic expressions in the open coding aspect of the analysis (see below). Therefore, theory *was* emerging from the data, as well as the extant theory of the researcher, as the participants would not have had the theoretical knowledge of the concept. Furthermore, from the consultation of the literature, it became apparent that little research had been conducted into how empathy was perceived to be expressed, and, as discussed in Chapter Four, the research that did look at this had either no video recordings and/or no multiple perspectives on where empathy was being expressed. The fact that this gap in the literature exists suggests that the researcher is less likely to be influenced, as the existence of the gap itself suggests that knowledge of the area is incomplete.

Theoretical sampling

Theoretical sampling has three features: choosing cases in terms of your theory, choosing deviant cases and changing the size of your sample during the research (Silverman, 2010: 144). Regarding the choice of cases, in the first instance two sets of data were collected back to back. Here, a *set* of data refers to one simulated consultation between a fourth year medical student, and a role-player playing the part of a simulated patient with haemorrhoids. The *set* also includes three lots of open coding, conducted by the researcher, role-player and medical student on where they deemed empathy to be present in the simulated consultation. Initially, the simulated consultations were recorded and participants were asked to watch them back and then debate about where they thought empathy was present. This did not work well, as the role-players were used to taking a leading role in the consultation skills training sessions, and thus dictated the debate to an extent. Therefore, it was decided that for the next set of participants, the simulated patient and medical student would code where they deemed empathy to be present separately. Hence, the

simulated patient was asked to leave the room while the student did his or her coding and vice-versa. This provided a much more comprehensive and unbiased method of coding, and was used with all of the remaining participants.

Once 14 sets of data had been collected, the data were taken to two members of the thesis supervisory panel: a psychotherapist and consultation skills tutor, to help decide what to show to PPIRes (see Chapter Six for a detailed description of PPIRes). In addition to deciding what data to show, both supervisors agreed that there was some difference between genders regarding the interaction. Therefore a single case set of data were collected involving one medical student conducting the same consultation with both the male and female simulated patient. Hence, the overall sample size included 16 sets of data. Regarding the sample size, it was initially estimated that between 20 and 30 simulated consultations would have to be conducted. However, through the incorporation of the medical students and simulated patients in the open coding process, theoretical saturation occurred much sooner than expected. Over 600 perceived instances of empathy were identified by all participants throughout the 16 consultations, and no new themes emerged after 11 sets of data were collected.

In relation to deviant cases, one problem with collecting the data over the course of nine months was that the medical students were gaining more and more knowledge of consultation skills throughout. An example of this is that during the course of the fourth year, students have a module on conveying risk to patients, and it was interesting that the students who participated earlier in the study were very keen to rule out the haemorrhoids being related to colon cancer, whereas those students who participated later would not rule it out, but express facts and probabilities about the likelihood of it being this. For example, Participant 006, whose simulated consultation was conducted in February 2011 says:

[006]

192 Patient: =so you're sure it isn't anything else
193 °°more serious°°

194 Student: no no °no° that's why >so with-with the<

195 scope they will've (.) um >y'know< if they
196 didn't explain this to you at the time
197 (0.5) they look sort of right round the
198 back

In contrast to this, Participant 010, whose consultation was two months later in April 2011, is much more ambiguous in ruling cancer out:

[010]

124 Patient: do you think they'd have looked to see if
125 it was (.) cancer or not (.) or

126 Student: well with the sigmoidoscopy they would
127 have been able (.) to check your um (1.0)
128 the lower part of your colon

129 Patient: right

130 Student: and um (.) obviously that doesn't (0.5)
131 exclude (0.5) everywhere

132 Patient: hmm-[no

133 Student: [near your bowel

The impact of the length of the study was not just relevant to the medical students however. As the data collection progressed, the role that the researcher played in the teaching of consultation skills on the MB/BS degree influenced opinions of what empathy involved. The impact of reading the codes that the students and simulated patients were using may also have influenced what was deemed to be empathetic. This was overcome to an extent through the triangulation of data between the researcher, medical student and role-player. However, to further add to the trustworthiness of the study, when all data were collected and transcribed, it was taken to a patient involvement group to obtain their opinions on whether they deemed it to be empathetic or not. These were a lay group, with little or no

theoretical knowledge about what the literature classifies as empathy, hence lessening the impact of the 'changing mind' of the researcher and immediate participants.

Coding

It has been asserted that 'coding is the core process in classic grounded theory methodology' (Holton, 2007: 265). In grounded theory, there are many different strategies used by theorists when coding data, and the type utilised in this research is most comparable with work of Charmaz (2006). The following terms best describe the different stages of the coding process used within this thesis:

> *Open/Initial Coding* - Open coding is the interpretive process by which data are broken down analytically. Its purpose is to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data (Corbin and Strauss, 1990: 12)

> *Focused Coding* - Focused coding is the second major phase in coding. These codes are more directed, selective, and conceptual than word-by-word, line-by-line, or incident-by-incident coding (Charmaz, 2006: 57)

> *Axial Coding* - In axial coding, categories are related to their subcategories, and the relationships tested against data. Also, further development of categories takes place and one continues to look for indications of them. Through the 'coding paradigm' of conditions, context, strategies (action/interaction), and consequences, subcategories are related to a category (Corbin and Strauss, 1990: 13)

> *Theoretical Coding* – Theoretical codes specify possible relationships between categories you have developed in your focused coding... theoretical codes are integrative; they lend form to the focused codes you have collected (Charmaz, 2006: 63)

Data were collected at intervals and was coded by three parties (the researcher, the medical student, and the role-player who had taken part in the simulated consultation) immediately after the simulated consultation. Participants were asked to code only where they deemed empathy to be present, paralleling the concept of initial coding (Charmaz, 2006). This method built upon the process employed by Suchman et al. (1997) where perceptions of empathy were triangulated between the researchers. In this project, the above method has been build upon by triangulating the perceptions of the medical students and role-players, in addition to the researcher, and this will henceforth be referred to as 'member coding'.

The participants were not primed about the study's preoccupation with empathy beforehand, thus the coding they did was – to the greatest possible extent - not influenced by extant sources, such as participants preparing for the session by reading up on empathy, or asking other people about their opinions on it. One problem here was that in order to maintain some consistency with the open coding, only two simulated patients were invited to participate. It must be considered that as they went through the data collection period, the role-players may have formed a greater understanding or appreciation for the intricacies of what constitutes an empathetic expression. However, the two role-players invited to participate had over 15 years experience between them with regard to OSCEs and consultation skills training (as described in Chapter 2), meaning that they were likely to already have a solid opinion on the matter. What they did not have was the theoretical knowledge stemming from the literature, thus giving a unique and vital take on the consultation.

The medical students' coding offered another unique perspective. By the fourth year, the students would have had between 10-13 consultation skills training sessions at the university. These sessions are based around an adapted version of the Calgary/Cambridge model of medical consultations (discussed in Chapter Two). While they do have some training in empathy skills, the sessions do not provide as much detail as the academic literature. However, it must be considered that since medical students had been taught a certain structure for expressing empathy, this may have affected their judgment as to what empathy was. For example Participant

004 seemed to relate her coding of empathy to the Calgary/Cambridge model. However, judging from the overall coding completed by the students, this was only apparent in a minority of cases.

The open coding in this study was not completed in the orthodox line-by-line manner (Charmaz, 2006: 50), but instead, participants were asked to code only sections of the simulated consultation where they deemed empathy to be present, or where they thought it should have been present. From this, the codes and concepts surrounding empathetic expressions emerged naturally: if empathy was expressed in the same way in a consultation, it would be coded in a similar manner by the same participant. For example, the researcher coded a section of the consultation as follows: 'seem fed up with it all'; the medical student coded the same section as: 'I commented that the patient seemed very fed up and that I could understand why'. Hence these codes overlapped semantically, and indicated that this section of the consultation was more likely to be comprehensible between participants. The above was expanded upon with a process paralleling focused coding. The open coding from all participants was brought together to form similar codes where applicable. For example, if one participant had used the code 'acknowledges discomfort' and another used 'said patient looked uncomfortable', these codes were combined and standardised to assist with the organisation and development of the coding.

Axial coding was then undertaken, where the concepts and categories from the open and focused coding were compared and related to each other. The data were transcribed and axial coded by the researcher between January 2011 and August 2011. From this, categories emerged where the coding overlapped as to how empathy was expressed. So for example, if the simulated patient and medical student had coded a certain part of the consultation as being empathetic for a similar reason, this then became a category. Following on from the axial coding, theoretical coding was conducted, where the categories were refined and integrated. The axial codes were delimited to only the core categories, where the opinions overlapped with two or more participants. These fitted into higher order categories, and were theoretically coded accordingly. Once the core categories had emerged, they were examined in

more detail, using analytic methods adapted from the fields of Conversation Analysis and pragmatics.

5.3.2. Conversation Analysis

Conversation analysis developed from the work of Harvey Sacks. Initially, he looked at a corpus of phone calls to the Los Angeles Suicide Prevention Centre. The centre was more likely to be able to find and help someone if they had their name, but they often found that callers would withhold this information. Therefore, Sacks set about examining the structure of the phone conversations, and where in the interaction you could tell that somebody would not give their name (Woofitt, 2005: 5). Some argued that conversation was too disorganised to study (Chomsky, 1965), but Conversation Analysis grew into a prominent methodological approach in the social sciences (Sacks et al., 1974), and it is now applied to many forms of interaction, including the workplace (Drew and Heritage, 1992) and healthcare (Heritage and Maynard, 2006, Campion and Langdon, 2004).

Conversation Analysis examines language as social action, and assumes that talk is systematically organised and ordered (Hutchby and Woofitt, 2008: 15). The research approach in this thesis assumes that the doctor-patient interaction has a specific structure, especially now consultation skills have been given more prominence and are taught formally in medical schools. This was especially pertinent to the sample used in this project, as the medical students at the UEA are taught a structure to use in consultations based around the Calgary-Cambridge model. However, unlike other studies of empathetic expressions (Wynn, 2005, Cordella and Musgrave, 2009, Martinovski et al., 2007), the choice of locally constructed context, function and meaning to be examined was derived from the coding conducted by the medical student, simulated patient and researcher. Another issue with the students being taught how to structure a consultation is that Conversation Analysis is interested in naturally occurring speech. Evidently, the fact that the medical students were taught a structure, and that the data were collected through simulated consultations, was juxtaposed with this logic. It could be argued that the data were natural in the sense that it is a true reflection of the processes conducted within an OSCE, although this

in itself is semi-scripted through the learned procedure set out in the medical students' learning of the Calgary/Cambridge model. However, this is less important to this research, as here the main focus is on how the tools of analysis are being utilised, rather than the epistemological considerations.

All of the data collected was transcribed by the researcher using an adaptation of Jefferson's glossary of transcript symbols (Jefferson, 2004), which are described in the Appendix. These transcripts were then used to assist in the coding and organisation of the data. In addition to this, the use of transcription also enhanced the referential adequacy of the data and analysis, helping to explain the findings in both the writing itself and at conferences, as the use of a standardised method of transcribing made it easier for others in the field to understand. Through the use of transcriptions, the analysis of the language which co-occurred with empathetic expressions was made clearer.

While this project does not follow the complex and intricate rigour of Conversation Analysis, there are sections of the analysis which draw upon some of the analytical methods involved. For example, section *8.1.5.* which discusses eliciting the concerns of the patient, *9.1.6.* which discusses the use of the phrase 'I'm sorry to hear that', and *9.4.3.* which discusses the technique coined as 'state then relate' all draw on the idea of sequential analysis to some extent. In addition, other sections of the analysis also build on the idea of sequential analysis to a lesser extent (*8.1.2., 8.1.4., 9.1.1., 9.3.3., 9.5.1.*), although it should be made clear here that the primary aim of this project was NOT to conduct a conversation analysis of empathy in the consultation, but to utilise conversation analysis to explore certain aspects which had been previously derived from the inductive quasi-grounded theory approach.

The use of CA in this project helps with analysing the participants' perceptions of what empathy is and where it occurs in interaction, rather than relying on the participants themselves attempting to arrive at conclusions. ten Have states that 'The verbal accounts participants might produce regarding their own conduct are rejected also, at least as primary data on the interactions accounted for. Experience shows that participants may not afterwards 'know' what they have been doing or why, and

furthermore tend to justify their behaviour in various ways' (ten Have, 2011: 31). Although this specifically relates to conversational features, it echoes the difficulties posed by examining empathy. Participants may be able to recognise the concept in interaction, but not explain why they perceive it to be so in terms of details, interaction and/or language. Hence this is why the inductive approach described previously was taken, in order to identify the parts of the interaction which were deemed to be empathetic, which could later be examined in more detail. In addition to the above, ten Have continues to state that 'while CA insights can be based on a generalized conversational competence that all 'members' are supposed to share and count on, the analysis of specialized activities, like doing laboratory work, require a relevant specialized competence, based on a third mode, 'acquired immersion', in order to fit the 'unique adequacy requirement' (ten Have, 2011: 48). Therefore, by getting the participants to identify where empathy was present, but not ask them to analyse why they thought it was present, the researcher could analyse the interaction involved with empathy, without making assumptions about what empathy was and how it was realised in interaction.

The above method is supported further by ten Have, who claims that '...in some kinds of 'applied CA' one might rather prefer a deliberately restricted set of instances, for example to a specific circumstantial category. In such a strategy, the interest is not in the activity-as-such, but in specific kinds of category- or context bound activities' (ten Have, 2011: 70-71). Hence in this situation, the specific kind of category would be the expression of empathy. Again, this links to the initial identification of empathy through member coding, and then the examination of these categories through a linguistic lens. This thinking is continued: 'when you are interested in a class of interactional phenomena that you expect to be particularly prominent in a, or some, specific setting(s), you might collect recordings from that or those setting(s) (ten Have, 2011: 71). This relates to both the coding itself, and also the choice of simulated consultations in undergraduate medical education. In a sense, a corpus of data is created through the participants coding where empathy is present, and this is something ten Have suggests as an alternative to traditional methods of CA when he states: 'an alternative could be firstly to construct a corpus, in this case of GP consultations, and then examine all instances of a rough category such as

‘questioning sequences’ in the manner of *comprehensive data treatment*. Or, one could firstly develop a topic [...] followed by the comprehensive data treatment of the relevant instances in a corpus’. In this project, the corpus of data would be the recordings and transcripts of simulated consultations, and the rough category would be any instances that were deemed empathetic during the member coding process.

One of the objectives in applying aspects of CA to the identified instances of empathy was to examine how certain sequences led to empathetic expression. John Heritage states that ‘in analysing sequences, we essentially look at how particular courses of action are initiated and progressed and, as part of this, how particular action opportunities are opened up and activated, or withheld from and occluded’ (Heritage, in ten Have, 2011: 180). However, as ten Have points out ‘the danger in this situation is that less talented, insightful, or sensitive practitioners may be tempted to “apply” the established concepts in a mechanistic fashion, as “coding instruments”’ (ten Have, 2011: 38). This was something which was avoided to the greatest possible extent in this project, as mechanistically applying theories and concepts from CA directly to the data may have moved the focus away from how empathy was actually perceived to be expressed by the participants. The findings emerged from the data (in the same way that original findings emerged from CA’s founders: Sacks, Schgloff and Jefferson). Hence, the quasi-grounded theory approach used to identify empathy meant that the researcher could not just focus on whatever aspect of the interaction they desired.

5.3.3. Pragmatics

The field of pragmatics also contributed to the analysis of perceived empathetic expressions in this thesis. Pragmatics is ‘concerned with the study of meaning as communicated by a speaker... and interpreted by a listener (Yule, 2000: 3). This relates to interaction in medical consultations, as the conveyance of meaning is essential with relation to both the patient and doctor. In order for empathetic expressions to work, the doctor must understand the message that the patient is trying to put across, while at the same time making sure that what they are saying is being understood as empathy. The term ‘pragmatics’ is attributable to the

philosopher Charles Morris, who saw it as a branch of inquiry within semiotics, along with syntax and semantics (Levinson, 1987: 1). It encompasses a number of sub-disciplines, which range from speech act theory to implicature to presupposition (Grundy, 2008), but the two aspects which are related to the scope of this thesis' research objectives pertain to politeness and cooperation.

Politeness

Politeness – in this case – does not just refer to saying 'please' and 'thank you'. It is a whole phenomenon based within the field of pragmatics, which hinges on the concept of 'face'. The notion of face was first proposed by Erving Goffman and refers to 'the positive social value a person effectively claims for himself' (Goffman, 1967: 5). It is 'something that is emotionally invested, and that can be lost, maintained, or enhanced, and must be constantly attended to in interaction' (Brown and Levinson, 1987: 61). Two of Goffman's students, Penelope Brown and Stephen Levinson expanded on this concept by dividing face into positive and negative categories, and it is these two concepts which are the focus of the politeness theory aspect of this research. Positive face is the desire that a person's actions are 'desirable to at least some others', and negative face the desire 'to be unimpeded by others' (Brown and Levinson, 1987: 62). Face threatening acts (FTAs) can lead to loss of face, which is an undesirable consequence for any person in society, and is especially significant when trying to build rapport with a patient in a consultation. Minimising the threat to face can be achieved in a number of ways, and this is summarised in Figure 1.

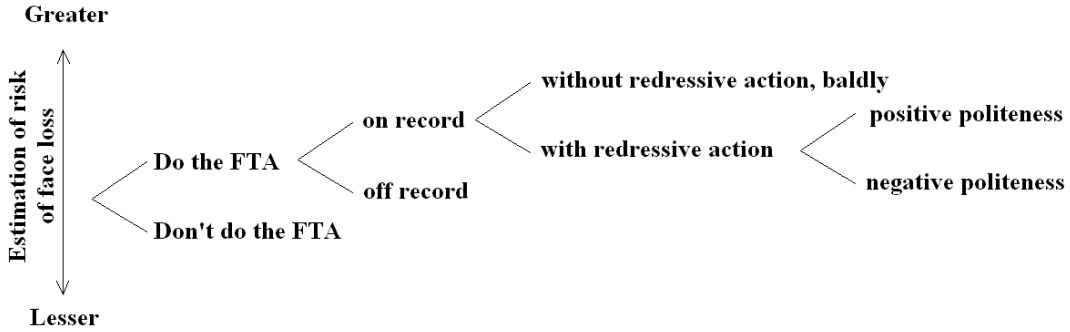

Figure 1. Circumstances determining choice of face strategy (Brown and Levinson, 1987: 60).

There are a number of ways to ask someone to open a window, all with varying degrees of directness. With reference to Figure 1, this particular request may be expressed as off record: 'It's hot in here', on record without redressive action: 'open the window', or on record with redressive action: 'do you think you could possibly open the window?' Therefore, it can be seen that by utilising a wide spectrum of direct to indirectness, an interlocutor may alter the amount of politeness they use with another, thus affecting potential face loss. Simplified, the more indirect the speaker is, the more face-saving the speech act becomes. When deciding on a politeness strategy, a number of factors must be considered, and these are shown in Brown and Levinson's statement (Brown and Levinson, 1987: 76) for the amount of politeness required in a given situation:

$$W\chi = D\,(S,H) + P\,(H,S) + R\chi$$

The social distance (D), power (P) and rank of imposition (Rχ) between the speaker (S) and hearer (H) may vary depending on how polite (Wχ) a speaker wishes to be. If the social distance between interlocutors is large, or if the act that the speaker is wishing the hearer to carry out is weighty, then more politeness is required. Therefore speakers may adopt some or all of the strategies previously listed. The power difference between the interlocutors will further affect the politeness strategy used, with the more powerful interlocutor requiring less emphasis on politeness strategies. This relates to doctor-patient consultations. The doctor is often seen as a role-model in society: someone to rely and depend upon, hence making the power

disparity greater. If it is the patient's first time meeting a certain doctor, then social distance will also be greater. It is assumed that a doctor's job is to help care for people, meaning that usual conventions involving imposition are less affecting; however, this can often be incongruous for the patient, and thus the doctor may utilise the above strategies to make them more relaxed and build a stronger relationship with them.

Cooperation

Cooperation between interlocutors in a doctor-patient consultation is essential to structuring the consultation, assisting with the diagnosis, and most relevant to this research, the building of the relationship. Within the field of pragmatics, cooperation has been examined with reference to Grice's cooperative maxims. Grice claims that when interlocutors speak with one another, they should attempt to 'make [their] conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which [they] are engaged' (Grice, 1975: 67). He divides this 'cooperative principle' into four maxims, which state the following:

> *Quantity*. make your contribution as informative as is required; do not make your contribution more informative than required.
>
> *Quality*. do not say what you believe to be false; do not say that for which you lack adequate evidence.
>
> *Relation*. be relevant.
>
> *Manner*. avoid obscurity of expression; avoid ambiguity; be brief (avoid unnecessary prolixity); be orderly (Grice, 1975: 69).

These conversational maxims must be adhered to in order for any conversation to be cooperative. The flouting (accidentally not abiding by the maxims) or violation

(purposely not abiding by the maxims) of these may result in a breakdown in the conversation, with one or more interlocutor losing face – an undesirable consequence for anyone in society, particularly a patient. This links to empathy from the point of view of concept not just being seen as simulation of emotion (as it has previously been treated (Suchman et al., 1997)) , but the more modern interpretation of the concept (Batson, 2009) of empathy being concerned with a multitude of simulation: feelings, thoughts, attitudes, values; and how these may be managed through careful and considerate cooperation within the interactional exchange.

5.3.4. Ethnography

To a lesser extent, the research conducted here is also ethnographic in nature. Although this is not a focus of the project itself, the fact that the researcher was involved with the delivery of consultation skills training within the UEA must not be ignored. Rather than minimising the influence this had, the circumstances were embraced to provide a unique perspective on the data. Any bias was overcome to an extent through the coding process, with power given to the other participants, who provided limits upon the researcher's coding power, as the codes had to be agreed upon with others for them to be considered empathetic acts. However, certain sections of the interpretation draw on these experiences of the researcher where relevant, in order to add any significant additional information which may augment the analysis and discussion. Due to the nature of the researcher's epistemological privilege in this case, reflexivity was essential throughout the research process. This is discussed at greater length in Section 6.6. which deals with the trustworthiness of the research.

5.3.5. Summary

To conclude, the methodological approach taken was split into two phases. The first utilised a quasi-grounded theory approach which paralleled the work of Charmaz (Charmaz, 2006), while the second phase explicated this initial analysis to scrutinise the findings with tools from the fields of CA, pragmatics, and to a lesser extent, ethnography.

CHAPTER SIX: METHODS

6.0. INTRODUCTION

This chapter discusses the methods of data collection and analysis, with information about what was done in the project, who was involved and the ethical considerations being described. The chapter concludes with a discussion about the trustworthiness of the research, including a section on the reflexivity of the researcher; since this is such an important aspect to the research, it is also alluded to throughout the chapter, and the thesis as a whole.

6.1. APPROACH

The study took a qualitative approach to examining the concept of empathy, influenced by the ontological and epistemological stances – and utilising the methodological tools – discussed in the previous chapter. The method attempted to build an inductive framework relating to how empathy is expressed through the incorporation of participant perspectives who are involved in the examination/training of medical students' consultation skills. Moreover, once this framework had been derived, it was examined more closely regarding the language and non-verbals which co-occured with these perceived expressions of empathy.

The core method of data collection consisted of simulated consultations, which paralleled the medical students' training and examination on the medical degree. This allowed for consistency in the method, with the same scenario, simulated patients, setting, and time limit being imposed. Rich data were obtained, which consisted of role-plays between medical students and simulated patients, and the perceptions of what was empathetic in these consultations from a number of different viewpoints.

6.2. PARTICIPANTS

Data were collected through simulated role-plays between undergraduate medical students and simulated patients from the Simpatico Role-play Agency (details of which can be found at the following: http://www.simpaticoagency.org/). The role-players at the time were employed on the consultation skills programme, and were paid for their part in the research. Two different role-players (one male, one female) were used throughout the project to ensure consistency in the consultations. The role-players invited to participate had a wealth of consultation skills experience between them, having participated for over 15 years in simulated consultations, and having worked with medical students at the UEA and The University of Cambridge. In addition, they had also done similar work at various hospitals around the East of England helping to further enhance doctors' consultation skills.

Participation for medical students was voluntary, and 15 undergraduate fourth year medical students were recruited to take part in the study before theoretical saturation of the data occurred. There were a number of difficulties recruiting students to take part, which ranged from ethical issues, to their willingness to take part. From 171 medical students, only 21 expressed an interest in participating (only 15 were required). This could be for a number of reasons, such as students being too busy with pressures of their degree, to not wanting to be videoed conducting a consultation. In retrospect, a monetary incentive or book token may have increased the response rate. It was originally anticipated that between 15-25 participants would be required to reach theoretical saturation of the data, and that this target would not be difficult to reach with other incentives (see below). The reason for limiting the selection to fourth year medical students was that the fifth year students may have been too preoccupied with their final exams, and any students from lower years would not have had adequate training in consultation skills to participate in the study. Having medical students with varying abilities should not have adversely affected the findings from this research, as it was the expression of empathy that was of interest, and not the individual students' ability to express it. Ideally, a range of abilities is useful for comparison; however, due to ethical constraints it was not possible to recruit students on the basis of their ability (reflected by their OSCE

scores). However, the students *were* asked which quartile they fell into on **Form 2B** (please note that all **Forms** are provided in the Appendix), and this data indicated that there was a good range of abilities (a summary of the baseline information on participants is included in Table 4).

Medical students were recruited through a formal letter and a participant information sheet (see **Form 1A and 1B; note that all forms are contained within the appendix at the end of the thesis**), which was emailed and posted to all fourth year medical students. These forms did explain the study's preoccupation with empathy, as it would have been deemed unethical not to state this. However, since the study was concerned with examining each participant's own interpretation of empathy, and how this was expressed and received during the simulated consultations, it is argued that this did not affect the credibility of the research. Even if the participants had gone and read about the concept (which seems unlikely), any additional opinions formed on what empathy was, or how it was expressed, would have become a part of their own perception of the concept; hence their coding would still have been a reflection of their own interpretations of the concept.

In addition to this method of recruitment, there were posters in the University of East Anglia's medical school building, where many of the medical students' seminars take place, to advertise the project (see **Form 1C**). Regarding the incentive for the medical students' participation in the project, each student was offered a copy of the recording to show to future employers in their portfolio, or to help them with their own training. Their participation was also something that they could list on their curriculum vitae and application forms.

Other participants relevant to this study came from the Patient and Public Involvement in Research (PPIRes). The role of PPIRes is described on their webpage:

> *'The PPIRes project gives you the opportunity to access, through the PPIRes coordinator, a panel of volunteers who are willing and able to assist you at all stages of the research process.*

> *All volunteers have, or are in the process, of attending training to learn about stages in research and how they could contribute. Volunteers have been recruited from a wide range of backgrounds and many have used health services extensively and have a disability or play a caring role. We also have details of organisations, which may be able to help to identify individuals with particular experiences to contribute'. (http://www.norfolk.nhs.uk/ppires-information-researchers)*

PPIRes were very enthusiastic about taking part in a retrospective focus group and helping to analyse if and where empathy was present in the data from a patient perspective. Their role was to help categorise the codes which had emerged from the initial coding, to verify the framework which emerged from the data, and to ensure that nothing had been missed or misinterpreted with regard to what empathy is perceived to be, and how it is expressed.

Table 4. Baseline data for student participants.

Participant Number	Sex	Age Group	Role before MB/BS	Nationality	Ethnicity	Languages other than English	OSCE Quartile
1	M	31-40	Full time work	British	South Asian	Urdu	B
2	F	18-21	School leaver	British	White British	n/a	A
3	M	22-30	Previous degree	British	White British	n/a	C
4	F	22-30	Gap year	British	White British	n/a	D
5	F	22-30	School leaver	Nigerian/British	Black Mixed	Hausa, Arabic, French, German	A
6	M	18-21	School leaver	Brtish	White British	n/a	B
7	F	22-30	Gap year	British	White British	n/a	B
8	F	22-30	Previous degree	British	White British	n/a	B
9	M	22-30	Full time work	British	Caucasian	n/a	C
10	F	22-30	School leaver	British	White British	n/a	B
11	F	22-30	School leaver	British	White British	n/a	B
12	M	22-30	Previous degree	British	White British	n/a	A
13	M	22-30	Full time work	British	White British	n/a	B
14	M	22-30	Previous degree/Full time work	British	White British	n/a	C
15	F	22-30	Previous degree	Pakistani	Asian	Urdu	D

6.3. MATERIALS

The role-play used in the simulated consultations came from the third year of the UEA's consultation skills module. The scenario cards were written by the consultation skills tutors in conjunction with clinical experts, and had already been used in the module, thus improving the accuracy of the scenario and also minimizing any potential ethical issues. Since all the participating medical students in the study were fourth years, they should have been familiar with the scenario, as it was in their third year handbook. The role-play involved a simulated patient coming to see a doctor with a case of haemorrhoids, and the role-players were sent a detailed description of the simulated patient they would be playing prior to the session (**FORM 3C**). The scenario was chosen as it provided opportunities for the medical student to empathise with the patient on a number of levels. Firstly, and most obviously, was the pain the patient was in due to the haemorrhoids. Secondly, since haemorrhoids occur in a very private part of the body, the medical student had to understand the embarrassment that the patient may have been feeling. Finally, since the patient's father died from colon cancer – which has a similar symptom to haemorrhoids: bleeding from the back passage – the medical student had to understand the worry that the patient was feeling, in case the haemorrhoids had been misdiagnosed. The medical students may have already conducted the scenario in their third year of study, however, this was not a problem regarding trustworthiness, as the research aimed to capture expressions of empathy in different ways in order to record the communicative features which occur with empathy, not to test students on whether they expressed empathy or not.

6.4. METHOD

Due to the iterative process involved in this project, the method itself is only briefly described in this section. It is more comprehensively dealt with in the next chapter, where a description of how the method informed the analysis and vice-versa is discussed.

In advance of a data collection session, the role-player and medical student were emailed information sheets (**Form 3C** and **Form 3D** respectively), which provided specific details about what the scenarios entailed. The data collection session began with the student reading the participant information form for students (**Form 1B**) and they then had the opportunity to ask the researcher any questions surrounding the project which the information sheet may not have covered. Once the participants had read the form and posed any questions, they were asked to complete the consent form (**Form 2A**) and a form to collect baseline data relevant to the study (**Form 2B**). The role-player was then asked to sign the consent form for role-players (**Form 3B**).

Audio-visual data were collected at the UEA in a room specifically set up to run the simulated consultation. Two Mini DV video cameras were set up to capture different angles of the medical student and simulated patient's consultation (one camera on each participant), and a flashlight was used to help synchronise the timelines later when editing. Recording the consultation ensured to the greatest possible extent that both linguistic and non-verbal details were not missed. However, non-participant observation was conducted from the corner of the room by the researcher to augment this, with the researcher's opinion of what should be classified as an empathetic expression being noted on **FORM 3E**. The medical students had a time limit of ten minutes, with a one minute warning from the researcher. This is the expected amount of time it should take the medical student to run this type of consultation both in practice and in an OSCE, and this helped improve consistency and comparability between different medical students' consultations. In addition, the same role-play scenario was used in all of the consultations to reduce the number of potential variables in the study, again enhancing the transferability of the data.

When the consultation was finished, there was a separate feedback session with the medical student and simulated patient, which aimed to obtain their views on where empathy was used and felt respectively, and this formed the basis of the analysis. The simulated patient was asked to leave the room, and the medical student watched the video back on a television connected to the camera via an AV cable. Whilst viewing the video back, they were asked to note down when and where they thought empathy was expressed on **Form 3E**. A timestamp was shown on the television

screen to give the participant a reference point when noting down where they thought empathy was present, thus making the recording of the empathetic acts as accurate as possible. The same process was then repeated with the simulated patient, with the medical student leaving the room to ensure that neither party influenced the other on where they deemed empathy to be present.

The audio-visual data were transferred to PC via an IEEE 1394 port and recorded directly to Adobe Premiere Elements. A flashlight was used as a reference point to help synchronise the timelines and edit down the videos to produce one file containing the simulated consultation from two angles using picture-in-picture technology (shown in Figure 2Figure).

Figure 2. Screenshot showing the use of Picture-in-Picture technology.

The data were then transcribed in Microsoft Word by the researcher, using conventions tools from Conversation Analysis with an adaptation of transcript symbols (Jefferson, 2004). Note that the font type was set to Courier New, as each

character takes up the same amount of space in the transcript, thus making overlaps, latch-ons and other linguistic devices clearer to transcribe. The data were then coded with reference to where the researcher, simulated patient and medical student thought empathy was present using the qualitative software package: 'Non-numerical Unstructured Data * Indexing, Theorising and Searching Vivo 9' (NVivo). The transcripts of the simulated consultations were loaded into NVivo individually as imported internal documents,

The transcripts could then be viewed, coded and annotated in NVivo. The initial coding, which was done by the researcher, medical student and simulated patient for each simulated consultation, was utilised as the initial coding categories, and this is discussed in greater depth in the next chapter. The data were then compared with the other medical students' performances from the other simulated consultations, and the subsequent coding conducted for each simulated consultation.

From this process, a model of how empathy was perceived to be expressed emerged, and this was then modified and adjusted to create a more comprehensive framework on which to build the analysis. This was done initially by the researcher in order to arrive at higher order categories which were more concise than the above, but the focus group also played a part in verifying this coding.

Extracts of the data and analysis were taken to a lay focus group. This phase provided a retrospective account of where empathy was present through member verification, as the data had already have been coded by the role-players and medical students by this stage. The core aim of this process was to verify the data, and ensure that the categories derived from the simulated patient, medical student and researcher's open coding had not missed anything. If the focus group deemed there to be an empathetic expression in the data which could not be mapped onto the paradigm derived from the data, then the model would be adjusted and modified to incorporate this, thus enhancing the trustworthiness of the findings.

The analysis was expanded based around the model of empathetic expressions which had emerged as a result of the coding and verification process described previously. Once these categories had transpired from the data, they were meticulously

examined with a focus on the language being used. Here, as described previously, elements from sociolinguistics were applied to the data, in order to examine the language which co-occured with perceived empathetic expressions. In addition to examining the language correlates, the accompanying gestures were also observed. However, a key point to make here is that the analysis of gesture was only conducted as an augmentation of the linguistic correlates. The analysis of individual empathetic gesticulation was beyond the scope of this thesis.

6.5. ETHICAL CONSIDERATIONS

Ethical approval for this research was granted by the UEA's Faculty of Health Ethics Committee, reference number: **2009/10-039**. There were a series of ethical issues relating to the project, ranging from the sample of medical students asked to participate in the project, through to the level of risk, consent and issues of anonymity and confidentiality. These are discussed in the following sections.

6.5.1. Sampling

The sample chosen consisted of fourth year medical students. By the fourth year, the medical students should be more adept at communicating, and hence be able to handle both the practical and emotional aspect of the role-plays to a greater extent. It may have been considered unethical to use participants from earlier years than this, as they would not have had the proper training to deal with these types of situation with adroitness and confidence. Moreover, using medical students in their final years would have been both impractical and potentially unethical, as it could have interfered with their preparation for their final exams. Ideally, students would have been selected based on their OSCE scores, but this information was confidential and unobtainable through the medical school, hence this categorisation could only be implemented after the data had been collected, as the medical student was asked to note down on **FORM 2B**, which OSCE quartile they fell into. One final note to make relating to the sampling is that all participants were recruited on a voluntary basis and were made aware that the main interest of the research was empathy, again

mitigating potential ethical issues relating to their personal or professional background regarding the subject.

6.5.2. Level of risk to subjects

Any research dealing with empathy as a topic is always going to pose at least some level of risk to the subjects participating. There were numerous factors relating the participants' personal backgrounds which may correspond strongly with the given scenario, in the process adversely affecting the participant(s). With regard to the sample selected, very little could have been done about this; however, it should have been nullified to an extent by the fact that the project was advertised as dealing with empathy, and that participants were recruited on a voluntary basis.

Medical students have to sit numerous consultation skills exams, and must make their own recordings with simulated and real patients to qualify and revalidate their various college exams. They also have to deal with similar scenarios once qualified; hence their participation in this research would appear to be beneficial to their medical education. Further to this, their participation in the project potentially assists future students in their situation to deal with emotionally charged situations in a more professional, caring and adroit manner. Note that if any students did find the process either stressful or distressing, there was myself and four trained consultation skills tutors who agreed to provide a debriefing for these individuals, although none of the medical students required this.

6.5.3. Consent

Informed consent was sought from both the role-players and the medical students participating in the research. They were asked to read the participant background information sheets (**Form 1B and 3A)**, which gave specific details about what the project entailed, and then given the opportunity to ask the researcher any questions that the information sheets did not address. Finally, they were asked to sign a consent form (**Form 2A** for medical students; **Form 3B** for role-players) before

participating in the project. Note that they were free to withdraw their participation and their data without it affecting their status on the *MB/BS* programme.

6.5.4. Anonymity and Confidentiality

Anonymity could not be guaranteed to the medical students, as the audio-visual recordings were used to help the focus group and the supervisory panel assist with various elements of the analysis, and by keeping this data as raw as possible, it enhanced the trustworthiness of interpretation. However, a guarantee was given that the data would be kept confidential, with only the supervisory team and the focus group allowed to view it should the medical student wish. The student was given the option on the consent form to allow the use of the data in presentations and teaching sessions; however, this was not necessary for their participation in the project. They were asked to opt in to allow the data to be used in this way, rather than opt out. Their transcripts are included in the Appendix of this thesis, although pseudonyms are used instead of real names to ensure privacy on the participants' behalf.

Only role-players who were willing to participate in the study and allow for the data to be used for the thesis, publications, presentations and teaching were requested from the Simpatico Role-Play Agency. They were asked to sign an altered version of the consent form (**Form 3B**), which gives permission for using the data in this way. Pseudonyms were used for the simulated patients in the transcripts (the name of the character they were playing), although they may still be recognisable to some people in the video recordings. The data were stored in accordance with the Data Protection Act, 1998. The Mini-DV tapes and two external hard drives were stored in a locked filing cabinet in a shared postgraduate office, which was always locked when not in use.

6.6. TRUSTWORTHINESS

The term 'trustworthiness' was coined by Yvonne Lincoln and Egon Guba (1985) to describe equivalent criteria from quantitative research, where credibility paralleled internal validity; transferability paralleled external validity; dependability paralleled

reliability; and confirmability paralleled objectivity. The reason for them coining these terms related to their unease that the pre-existing terms associated with quantitative research presupposed that a single absolute account of social reality was feasible (Bryman, 2008: 377). Since this thesis treated empathy as a socially constructed phenomenon, these terms seemed best tailored to assessing the quality of the research, and the following sections detail aspects of the credibility, transferability, dependability and confirmability of the method.

6.6.1. Credibility and Reflexivity

Credibility refers to ensuring 'that research is carried out according to the canons of good practice *and* submitting research findings to the members of the social world who were studied' (Bryman, 2008: 377). Relating to the first point here, the reflexivity of the researcher must be considered. At the time of writing, the author had worked as an associate tutor on the consultation skills module at the UEA throughout the three years of research. It could be argued that this exposure may have improved sensitivity to intricate aspects of the consultation and hence increased the likelihood of being able to identify subtle linguistic and non-verbal devices used by participants to express empathy during simulated role-plays. Conversely, it could be considered that the exposure may have had a detrimental impact upon the ability to analyse the more sociolinguistic aspects of the consultation; the teaching methods used at UEA using the Calgary/Cambridge model may have become the prevalent way of analysing the consultation. However, the consultation skills training undertaken by the researcher was spread out into phases, with a majority of the teaching occurring at intervals throughout the academic year (for example, there were Year Two training sessions in February 2012, but then nothing until May 2012). The space in between these sessions allowed for the methods used in the consultation skills training sessions not to overshadow the interactional analysis that had previously been used, but at the same time, it helped to focus the research and ensure that the theoretical aspects had practical and feasible applications to the delivery of consultation skills training. Moreover, the data were collected over the period of time between November 2010 and June 2011, and a conscious effort was made on the researcher's part to not work on the thesis during periods of teaching,

which further helped to avoid mixing the work done in consultation skills with the interactional analysis conducted in this thesis.

The background of the researcher was in applied linguistics. Having completed degrees in English language with linguistics, and applied linguistic research, there was a heavy emphasis on the language involved in communication, but little knowledge of the concept of empathy coming into the project. Initially, the analogy of 'putting yourself in someone else's shoes' was the starting point for what empathy involved, and once it was decided that the project would use an inductive approach, a conscious effort was made to avoid forming a firm view on the concept of empathy itself until the data had been collected, as this may have biased the perception of the concept and hence the coding. Evidently, this was not entirely feasible, as other papers which required reading to provide foundations for the research discussed various interpretations of the concept. Moreover, it made it difficult when speaking to other academics about the work being done, as they expected a fixed view of the theories surrounding the concept. However, an awareness of this assisted in the avoidance of forming one firm view of what empathy was until the coding had been conducted by the researcher. It was only once this coding had been completed that the literature was again reviewed, and the theories surrounding the concept of empathy were scrutinised in more detail (an overview of this is provided in Chapter Two).

The first elaboration on the definition 'putting yourself in someone else's shoes' came from learning about the concept of empathy as it had been used in neuroscience; particularly, the work of Lewis (2007) and Decety and Ickes (2009). Although the definitions of what empathy was contrasted within these sources, my own interpretation and amalgamation of the definitions advocated empathy as imagining or simulating what someone was thinking or feeling. This seemed to contrast with the concept of sympathy, which was understood to involve taking these imagined emotions on yourself. However, when discussing these ideas at the Conversation Analysis and Clinical Encounters (CACE) 2011 conference, a sociologist criticised these definitions, and insisted that sympathy involved disaffiliating oneself with another, whereas empathy involved affiliating oneself.

After some consideration of the matter, it appears the most likely explanation for these differences is the background of the researcher. Hence neurologists may consider empathy as a mechanism working within the brain, whereas a sociologist may be more interested in the performative process of empathy in society. Both interpretations of empathy have their own merit, and do not appear to be mutually exclusive; hence both these interpretations contributed to the coding process on the researcher's part.

To further enhance the credibility of the study, the findings were submitted to members of the PPIRes focus group for member validation. This allowed for the initial model which was developed from the data to be checked, and also permitted the addition of external factors to the model which were not involved in the interactional sequences directly, but still had a bearing on the empathetic content. In addition to this form of member validation, the member coding included as a part of the study further improved credibility. Through the triangulation of the perspectives a more comprehensive account of empathetic interaction was derived from the data. Since empathy is a socially constructed concept, it manifests itself in different ways with different people. Hence by adopting this form of coding, more of these manifestations were included in the framework, thus giving a more complete account of how members involved in medical education deemed empathy to be expressed.

6.6.2. Transferability

Regarding the transferability of the project, Lincoln and Guba state that one 'can provide only a thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether the transfer can be contemplated as a possibility'(Lincoln and Guba, 1985: 316). This was potentially affected by the role that the observer's paradox (Labov, 1966) could have had on the participants, as it may have affected their natural manner, and thus decreased the repeatability/transferability of the results. The combination of two video cameras focused on the student and role-player, in addition to the observation conducted by the researcher could have had numerous effects on the participants' performances. Previous research has suggested that the use of video cameras can result in the

participants becoming more self-aware and anxious, and that this affects the person's external behaviours (Nezlek, 2002), thus potentially polluting the behavioural correlates of empathetic expressions. A potential change in external behaviour is also suggested in other research, noting that when a participant is being video recorded, they may behave in an 'atypical' manner (Coleman, 2000: 423). One study explored videotaped recording as a data collection method (Latvala et al., 2000), and – although behaviour change was noted as a limitation of the data collection process – the study also discussed the advantages of being able to work with rich data where useful interaction and behaviour can be captured.

In contrast to the above, some studies showed that the use of cameras had little or no impact upon the behaviours of participants. One study reported that 'no significant difference owing to awareness of video recording was found in consultation length, the number of problems dealt with, or previous inexperience of video recording' (Pringle and Stewart-Evans, 1990: 455). This was supported by another study, which concluded that while an observer effect could not be ruled out, the effect of being videotaped 'may not be as exaggerated as some people suggest' (Carpenter and Merkel, 1988). Regarding anxiety levels in response to being recorded, it has been reported that the use of audio-visual equipment has no significant difference on participant performance (Lichton, 1995); although the author does acknowledge that this may have been linked to the low visibility of the cameras in the study. A more recent study examined camera reactivity in medical interactions (Penner et al., 2007), where the recording devices were concealed from the participants. One of the key findings from this study was that behaviour changes occurred most often in the early stages of interaction, after which the participants' interaction appeared to revert back to a more natural state. It must be remembered that in accordance with their consultation skills training to date, medical students are expected to fully introduce themselves and then allow for a golden minute[6] with the patient. Thus, it was anticipated that by the time these two sections of the consultation had been

[6] The one minute slot at the start of the consultation for the patient to discuss why they have come to see the doctor, which is the current method taught at Norwich Medical School.

completed, the interaction would become more natural. An important point to highlight here is that the term 'natural' refers to what would be expected from the medical student and role-player in a simulated consultation during an OSCE or consultation skills training session. By definition, simulated consultations are not natural, but the ones conducted in this project must parallel what goes on in the training/examinations. Therefore, to increase the consistency between the data gathered in this project and the medical students' performances in training/examinations, the role-play scenario was taken directly from the UEA consultation skills module.

6.6.3. Dependability

Dependability involves the researcher ensuring 'that complete records are kept of all phases of the research process – problem formulation, selection of research participants, fieldwork notes, interview transcripts [and] data analysis decisions' (Bryman, 2008: 378). All of the transcripts from the focus group meeting and the simulated consultations were transcribed by the researcher, and are available in electronic format on the compact disc included with the thesis. For purposes of anonymity, the video files of the participants were not made available for general viewing, other than in specific conferences and teaching sessions. The medical students had the option to give consent for the data to be used in this way on the consent form (**FORM 2A**), and all but consultation 015 and 016 agreed to this. The data were transcribed using an adaptation of Jefferson's Glossary of Transcript Symbols (Jefferson, 2004) to provide a standardised and hence understandable representation of the data for other researchers to draw conclusions about the transferability of the findings to their own work.

Procedure of analysis and interpretation was documented using NVivo, with the coding conducted by the participants being inserted into the transcript using NVivo's node feature to display which participant deemed a certain section of the consultation to be empathetic. Moreover, when one of these nodes was placed, an annotation was also inserted in the corresponding transcript text to describe exactly what the participant was coding (for example, 'discomfort', or 'checking current knowledge').

The fact that the coding was done by multiple participants further adds to the dependability. The analysis of the data was made easier through referential adequacy: making video recordings as well as live non-participant observation allowed the data to be examined by not only the researcher, medical student and simulated patient, but also verified by the focus group. This in itself acted as a form of triangulation of the data, with numerous investigators assisting in forming an interactional theory of empathy that was as true and accurate as possible. To further increase the dependability of the project, overlap methods were employed; the data were triangulated between the researcher, thesis supervisory panel and focus group, and also compared to findings from the literature.

6.6.4. Confirmability

Confirmability 'is concerned with ensuring that, while recognising that complete objectivity is impossible in social research, the researcher has acted in good faith' (Bryman, 2008: 379), and there were a number of measures which helped enforce this in the data. This had already been discussed to a certain extent with the section on credibility detailing the reflexivity of the researcher. In addition to this, the use of theoretical saturation helped with the confirmability of the data. As previously discussed, the recruitment of medical students was only closed once no new themes were emerging from the data: any coding conducted by the participants could be mapped into the previously developed categories. Saturation of behavioural correlates had occurred by the time the twelfth participant had been recruited, but an additional four sets of data were collected after this, to ensure that saturation had been reached. The use of the various member coding from students, simulated patients and the focus group further enhanced the confirmability.

SECTION THREE

CHAPTER SEVEN: INITIAL FINDINGS

7.0. INTRODUCTION

This chapter begins by describing the iterative process used in the analysis of the data. The initial findings from this analysis are then presented and a theoretical paradigm of perceived empathy in interaction developed from this. The contribution from the focus group is then brought into the analysis to further augment the paradigm, and highlights that empathy can be seen as a form of practice within the medical profession, which encapsulates not simply the interaction which happens in the consultation, but the whole process which occurs pre and post consultation. Finally, the chapter concludes with a discussion surrounding the coding of gesture and non-verbal behaviour in the data.

7.1. THE ITERATIVE PROCESS OF METHOD AND ANALYSIS

The iterative process of the analysis allowed for the evolution of rich data and aided in the reconciliation of the qualitative interpretive approach. In the data collected, the participants were not external to the consultation. Rather than being a weakness of the project, this was built into the methodology as a positive strength of the approach. The participants, both students and simulated patients, were involved within the creation and analysis of the data firsthand. This gave them each a distinct perspective on the data that no-one, including the researcher, could have had. In essence, they 'lived through' an aspect of a simulated consultation that no-one else had, and hence could provide a valuable and unique take on if and where empathy was present.

As previously suggested, the process of data collection and analysis was iterative in nature, and the stages for this are described in detail in the following sections. These sections cover the 'piloting' of the study, the choice to then focus on participant perspectives rather than definitions, the process of further data collection and

evolution of initial categories, the axial coding of these categories, the development of an initial model, the validation and refinement of this model by the focus group, and the brief examination of gesture and non-verbal behaviour. The explication of the model using sociolinguistic tools from conversation analysis and pragmatics is detailed in the following chapters.

Note that a limit here pertains to the fact that the consultations were simulated. However, this follows from the current method of teaching in many UK medical schools, where role-play is used in the teaching of consultation skills. In addition to this, the methods parallel the specific process of teaching used at UEA. Hence, it is argued here that the data being collected was more accurate and valid, as it was more closely related to what the thesis was aiming to examine: medical education and consultation skills training. The method also mitigated the potential effect of the observer's paradox to an extent, as by paralleling the sessions at UEA, the students would have been more familiar, and hence more comfortable and natural in conducting the simulated consultation.

Pilot

The first two sets of data collected may be considered 'pilot studies' in the sense that the data gathered informed the progression of the study, and added to the iterative process (where the quasi-grounded theory evolved from). Originally, it was anticipated that the simulated consultations would help the participants give concrete examples in forming their definitions of empathy, and that the perceptions of where empathy occurred would be used to support this. These would be defined through discussion between the simulated patient and the student, with ideas about what empathy was, and where it occurred in the data, being derived there from. However, it became apparent after the first two data sets had been collected (the 'pilots') that asking participants to define empathy was not the best method of assessment. In both these sessions, the role-player had too much control, and led the student rather than collaborating with them in the derivation of the definitions. Essentially, this part of the method was too closely connected with the feedback process which is incorporated into the consultation skills training sessions at UEA, with the simulated

patient giving feedback and talking very generally about empathy (e.g., 'you were very empathetic', 'you acknowledged my concerns' etc) rather than relating their comments they had coded as being empathetic. Hence, a decision was made to focus the data collection of the perceptions of empathy, rather than the participants' definitions of the concept. The process of how this was achieved is described below.

First Phase

The simulated consultations were conducted and a process related to grounded theory's initial coding (Charmaz, 2006) was implemented. However, unlike traditional grounded theory (Glazer and Strauss, 1967) the initial coding was conducted from three distinct perspectives in order to triangulate the perceptions of empathetic expression in relation to those involved in medical education. A variation of this method was employed by Suchman et al. (1997) in the identification of empathetic instances, but was only carried out from the perspectives of the researchers working on the project. This method of triangulating participant perspectives shall henceforth be referred to as 'member coding'. The initial coding process itself began with the researcher using a single code: 'empathy', and noting down the time and a brief description of any act which they deemed to be empathetic. The consultation was timed by the researcher and this meant that when an empathetic act occurred, the exact time could be noted down to make referring back to the data at a later date more accurate. Evidently, coding the data 'live' rather than watching it back at a later time meant that there was a possibility that some empathetic acts may not have been coded. However, the alternative to this would have been to code the data after both the student and simulated patient had also done so, which may have affected perceptions of what was empathetic, and thus would have made the findings less valid.

Once the consultation had been completed and the researcher had coded the data from their perspective, the student was asked to code where they deemed empathy to be present from their perspective in the same manner. The simulated patient was asked to leave the room and the student was given the video camera and control of the camera functions. The camera was connected up to a television so that the

consultation could be viewed back in more detail, with a bigger screen and higher quality sound. The participant watched the video with the camera primarily aimed at the student, with the simulated patient at a slight angle. Hence, the participant could view the consultation back at a pace which suited them; rewind, pause etc, so they could give a more detailed account of their perspective relating to where they deemed empathy to occur. In addition to this, a timestamp was visible on the television screen for the participants to write down the exact time the act they were coding occurred, and also helped the researcher at a later data when analysing and grouping the data.

The participant was then given **FORM 3E**, which stated: '*Please review the consultation, and note down where you believe empathy is being expressed. Please describe the sections where this happens, and the time of occurrence (the time will be present on the screen)*'. This was elaborated upon by the researcher in each instance without exception, as it felt more natural to speak to the participant about the task and give them the opportunity to ask questions about the coding process. In most cases, the participant actually initiated a conversation about the coding process, and so the above process seemed the most logical way to give the required information. The general information given at this point involved:

1) A comment about viewing the consultation back on the television
2) An explanation of how to use the video camera and functions (pause, rewind, etc)
3) The type of coding they should be undertaking: the participant's own interpretations and/or perceptions of where empathy was expressed with the simulated patient
4) An explanation of how to use **FORM 3E** with the method of time stamping, and briefly describing the act. Also, if it was a longer segment, the participant was advised to write in the first few words, and then '...' and then the last few words

The above process was then repeated with the student standing outside the room, and the simulated patient coding where they deemed empathy to be present. By

separating the participants in this manner, it ensured that neither participant influenced the others' codes, this making it a more accurate representation of where empathy occurred.

Second Phase

The recorded consultations were edited using Adobe Premiere Elements. Two video files (one from each camera and hence each angle) were transferred to PC via an IEEE 1394 cable. The first file was loaded into Adobe Premiere Elements and edited so that the light from the torch went out two frames before the start of the actual consultation (some irrelevant video had been recorded prior to this as a by-product of setting up the cameras). Once this was complete, the second video was loaded into Adobe Premiere Elements, and the same process undertaken. The two files were then merged together, one on top of the other, and the use of the technique with the flashlight meant that the files could be lined up with regard to timing, and hence run simultaneously using Picutre-in-Picture technology (shown previously in Figure 2). The use of this technique meant that the researcher could view more of the interaction when transcribing, and understood more about what participants had coded as empathy, and where they had done this.

Each of the 16 consultations were transcribed by the researcher using transcription conventions based around Jefferson's (2004) work. The full list of conventions used in this thesis is contained within the appendix. The data was transcribed between November 2011 and June 2012, and totalled 196 pages of transcription. All of the transcripts are included in .pdf format on a compact disc, which is a part of the accompanying materials. The data was primarily transcribed for purposes of practicality: to assist with grouping and analysing the data. However, it was also utilised to provide some sociolinguistic analysis as the iterative interplay of method and analysis evolved. The process of the researcher transcribing the data by hand allowed for greater immersion and thus familiarity with the data. Each consultation took around 12-15 hours to transcribe and check over for accuracy, hence during this period, the researcher was watching and re-watching the same consultations over and over, thus gaining familiarity with the data. It is also important to highlight that at

this stage of the data refinement process, the coding conducted by the participants had not been looked at by the researcher in an attempt to avoid contamination of what was deemed to be empathetic. This said, after the first transcript had been completed and coding examined, the researcher had a better idea of what was likely to be coded (e.g., the coding of 003 had been completed before 005 had even been transcribed).

Third Phase

The software program NVivo 9 was utilised to help with the organisation and coding of the data. The transcripts were loaded into NVivo individually as Word Documents (individually meaning the transcript from each consultation, such as 003, was loaded in as an individual Word Document). The initial coding collected on **FORM 3E** was transposed onto the transcripts. From this stage, categories began to emerge from the coding process. This stage of the coding process (which shall henceforth be referred to as the focussed coding stage) was the researcher's understanding and interpretation of the initial member coding. Each of the transcripts was examined one at a time and the initial member codes were plotted onto these transcripts using NVivo's coding and annotation features.

The actual development of the categories was complex and iterative in nature. Certain sections of the transcripts had been coded by more than one participant (this was partially the intention of using this method: to find overlapping perspectives of empathy); however, the phraseology used by the participants on **FORM 3E** slightly differed. For example, to describe an empathetic act involving asking about the patient's comfort, one participant may have written 'comfort discussed', whereas another may have written 'speaks about comfort'. It was the researcher's prerogative to group these codes accordingly – hence in this theoretical example, the code may have simply been written as 'comfort'. An important note to make here is that if the annotations were not grouped at this stage, then there was further scope for this later in the coding process to ensure rigour in the development of theory. Also, it is important to stress that at this stage of the coding process, the description of the codes given were very much in their infancy, and not fixed, so if a more logical way

of grouping the codes arose later in the process, they would be adapted. This process further enforced the iterative process running through the methodology of this project.

The following section discusses the actual coding process and how this was undertaken. The first consultation which was coded was 003, hence this is used in the example below to demonstrate how the initial categories emerged from the data (the first set of coding was done for 003 as this was the first transcript that was finished; the order was irrelevant – only the content).

In 003, the first aspect of the consultation coded as being empathetic by the student occurs on line 45. On **FORM 3E** the student wrote the phrase 'are you feeling okay' which refers to the specific part of the interaction represented on line 45 of the transcript and also had a time stamp relating to this specific part:

[003]

43	Patient:	so i'm i'm just here today to sort of
44		discuss (.) what the next step is really
→ 45	Student:	okay (.) okay (.) urrm (.) a::nd are you
46		feeling okay about (.) having having a
47		haemorrhoid (.) what do you want to (.)
48		to[
49	Patient:	[well really er the worst thing for me i
50		mean >um it is um embarrassing< it's not
51		something that
52		you[
53	Student:	[yeah
54	Patient:	talk about to people

Hence, this information was mapped into NVivo. The relevant feature was highlighted and linked to a free node called 'Student' in the program. In addition to this, an annotation was created for the highlighted text providing a brief and general description of the act; in this case, the description was 'Patient Feelings'. The same process was repeated for the next description provided by the Student on **FORM 3E**. The second description from the student said: 'We'll try to get something sorted out'. The description and timestamp related to the following section of the transcript:

[003]

```
65   Student: okay (.) well °sure sure° it must be
66             painful[
67   Patient:          [mmm
→ 68 Student:  um (.) alright well >we'll we'll< really
69             try and get something (.) sorted out=
```

In this example, it can be seen that the phraseology of the student's description of the act in question is not exactly the same as the actual utterance that was spoken. Hence, as previously mentioned, it was the researcher's prerogative to interpret which aspect of the interaction the student was coding in this case. This was done with the assistance of the timestamp, and it also seems logical that this would be the aspect of the interaction being referred to from the description. However, it must be remembered that this is a limitation of the project: that there may be minor misinterpretation on the part of the researcher relating to the Role-player and Student's coding, although strict measures such as the timestamp and description were in place to minimise this effect. In this specific example the section '`>we'll we'll< really try and get something (.) sorted out='` was interpreted as the empathetic act and the annotation given was 'Agenda Setting'. The above process was repeated for the remainder of the transcript, feeding all of the coding completed by the Student into the NVivo database using both codes and annotations to provide referential adequacy.

Once all of the student's data had been entered, the Role-player and Researcher's coding was also transposed into the same NVivo database. In a number of cases, the Role-player and Researcher had coded the same section of interaction as the Student had for being empathetic. For example, the Role-player wrote 'are you feeling okay about them' on **FORM 3E**, which, judging from this description combined with the timestamp, related to the same aspect of the consultation that the Student had described as being empathetic in the first example above. Hence, this suggested evidence of an act which was more comprehensible from a range of perspectives, and thus this informed the development of the categories within the empathetic model; in this case, the idea of checking the patient's attitude/feelings about the ailment was used as a starting point for developing the categories. Note that while it is impractical to describe each annotation and code applied step-by-step here, Table 5 displays all of the empathetic instances which were coded, which participants coded these instances, and how these instances were categorised by the researcher.

Fourth Phase

Building on the process above, the fourth phase of analysis involved all of the other transcripts (only 003 is discussed above) being analysed in the same manner. The core difference between this phase and the previous one is that here the codes which were mapped onto the transcripts were continuously contrasted and compared in an iterative process to help develop the categories further. This process took two forms:

1) The researcher comparing and contrasting codes 'on the fly'; that is to say if a participant had coded a piece of data in a similar manner to someone from a previous transcript, then an attempt would be made by the researcher to standardise those codes.

2) The annotations being taken once all data had been annotated and coded, and linking similar themes and categories together to create a model of empathetic expression.

This process was based around the concept of axial coding (Charmaz, 2006), as the categories which had emerged from the previous transcripts were being utilised in the newer transcripts. If no category existed to link a certain act to, then a new category was created by the researcher. This process was designed to aid with the idea of theoretically saturating the data, and allowing the themes and categories to arise from the data. Once a point had been reached where no new categories emerged it would suggest that the data had been saturated, and was comprehensive enough to propose a model of perceived empathetic expression. Evidently, this method of saturation would have been extended were another scenario were introduced, but that would have been beyond the scope of this thesis, and is an area for further work.

Below is an example of how this method worked in practice. The following example comes from the dataset 004, and the data from the participants relating to this transcript was fed into NVivo after dataset 003 had been completed, hence a number of categories had already been derived from the data at this point, including the aforementioned 'Patient Feelings'.

[004]

```
220   Student:  well um there are treatment options
221             available (0.5) erm (.) depending urm
222             which surgery depends on which options as
223             well (0.5) um there's treatments that can
224             just help towards your symp↓toms so things
225             just like the pain (.) and then there's
226             also treatments that aim to cure [they aim
227             to um get rid of them[

228   Patient:                          [right
229                                    [okay

→ 230   Student:  um (.) what are your feelings about (.)
231             [those
```

When examining the data fed into **FORM 3E**, the phrase in dataset 004 on line 230 is coded by the Researcher as being an empathetic expression, shown by the

description ‘what are your feelings about this’, and the relevant timestamp on the form. With this particular example, the content of the coded utterance was deemed to correspond with an annotation which had previously been used in dataset 003: ‘Patient Feelings’. Hence, this added supporting evidence to the category concerning the patient’s attitude/feelings. This process permeated the entirety of the methodology; the iterative nature of comparing where empathy was perceived to be expressed by one participant in one transcript, then multiple participants with the same transcript, then multiple people with all the transcripts thoroughly helped to create and develop the final categories. Once all of the data from all of the completed **FORM 3E**s had been transferred into NVivo, and subsequently all of the transcripts had been annotated, the annotations were printed off as a list for further refinement of the categories. This functioned as a method of double checking the categories which had emerged during the annotation and coding process. For example, if two categories could be logically grouped, then a single category for both was created.

The following table (Table 5) shows how this iterative process evolved and the coding of the categories emerged. It is sequenced in order of the simulated consultations (from 001 – 016), and demonstrates which participants coded which acts as being empathetic, and also how these acts were subsequently categorised and sub-categorised by the researcher. Each example is given an identification number, and these are referenced in the following two chapters to make it clearer which section of the text is being referred to in the examples. Note that these references are distinguished from the transcript numbers, as the transcripts are prefaced by a ‘0’, e.g., ‘014’ refers to transcript 014, but ‘14’ refers to the 14th example in the following table.

Table 5 showing all identified instances of empathy, and which participants identified them (where Y indicates the feature was coded).

ID Number	Consultation	Line Reference	Researcher	Student	Role-player	Category	Sub-Category
41	001	80	Y			Patient Knowledge	Current Knowledge
57	001	57	Y			Patient Knowedge	Treatment Options
61	001	228			Y	Patient Knowledge	Praise of Patient Knowledge
66	001	192	Y		Y	Comfort	Immidiate Comfort
75	001	99	Y			Lifestyle	Occupation
106	001	72	Y		Y	Agenda Setting	Patient Agenda
121	001	167	Y			Agenda Setting	Future Action
125	001	282	Y			Checking Understanding	Understanding Doctor's Explanation
142	001	116 and 119	Y		Y	Information Retention and Attachment of Condition	State then Relate
144	001	155			Y	Reassurance Strategies	Use of 'Understandable'
164	001	167	Y			Reassurance Strategies	Positive Outlook and Future Support
172	001	301	Y			Professional Perspective	Opinion on Emotions
#	001	301	Y			Comfort	Continuing Comfort
#	001	174	Y		Y	Patient Feelings	Isolation
18	002	235	Y			Patient Feelings	Pain
48	002	47	Y			Patient Knowedge	Desire for Knowledge
58	002	137	Y			Patient Knowedge	Treatment Options
67	002	69	Y		Y	Comfort	Immidiate Comfort
84	002	53	Y		Y	Rapport Building	Offering
88	002	226	Y			Rapport Building	Praising
107	002	25			Y	Agenda Setting	Patient Agenda
112	002	48	Y		Y	Agenda Setting	Relevance of Doctor's Agenda

151	002	192	Y			Reassurance Strategies	Severity of Ailment
170	002	147	Y		Y	Professional Perspective	Opinion on Emotions
4	003	45	Y	Y		Patient Feelings	Attitude to Ailment
10	003	282		Y		Patient Feelings	Desire for Treatment
22	003	354			Y	Patient Feelings	Embarassment
35	003	348	Y	Y	Y	Patient Feelings	Isolation
44	003	317			Y	Patient Knowledge	Current Knowledge
45	003	116				Patient Knowledge	Current Knowledge
65	003	188		Y	Y	Comfort	Immidiate Comfort
69	003	266		Y		Lifestyle	General
108	003	27	Y	Y	Y	Agenda Setting	Patient Agenda
116	003	68		Y		Agenda Setting	Future Action
152	003	345	Y			Reassurance Strategies	Severity of Ailment
162	003	296	Y			Reassurance Strategies	Positive Outlook and Future Support
168	003	65			Y	Professional Perspective	Opinion on Emotions
175	003	251	Y	Y	Y	Professional Perspective	Opinion on Emotions
#	003	307	Y			Patient Feelings	Isolation
3	004	230		Y		Patient Feelings	Attitude to Ailment
12	004	91		Y	Y	Patient Feelings	Desire for Treatment
17	004	332	Y			Patient Feelings	Pain
32	004	54	Y			Patient Feelings	Concerns
37	004	100	Y			Patient Knowledge	Current Knowledge
46	004	117	Y	Y		Patient Knowledge	Current Knowledge
49	004	114	Y			Patient Knowedge	Desire for Knowledge
70	004	70	Y		Y	Lifestyle	General
71	004	379		Y		Lifestyle	General
72	004	51	Y		Y	Lifestyle	General
76	004	88		Y		Lifestyle	Occupation
117	004	91		Y	Y	Agenda Setting	Future Action

137	004	211	Y			Information Retention and Attachment of Condition	Support and Future Treatment
141	004	143 and 144	Y	Y	Y	Information Retention and Attachment of Condition	State then Relate
181	004	379		Y		Professional Perspective	Opinion on Lifestyle
#	004	165	Y	Y		Patient Feelings	Isolation
5	005	67	Y	Y	Y	Patient Feelings	Attitude to Ailment
24	005	43	Y	Y	Y	Patient Feelings	Embarassment
59	005	72	Y			Patient Knowedge	Treatment Options
77	005	167 and 175	Y	Y	Y	Lifestyle	Occupation
153	005	242	Y			Reassurance Strategies	Severity of Ailment
163	005	293	Y			Reassurance Strategies	Positive Outlook and Future Support
179	005	66	Y	Y	Y	Professional Perspective	Opinion on Lifestyle
#	005	304			Y	Comfort	Continuing Comfort
#	005	313			Y	Agenda Setting	Expanding the Agenda
16	006	409	Y			Patient Feelings	Desire for Treatment
31	006	199	Y			Patient Feelings	Concerns
38	006	30	Y	Y		Patient Knowledge	Current Knowledge
80	006	73		Y	Y	Lifestyle	Occupation
81	006	504		Y		Lifestyle	Occupation
103	006	555			Y	Rapport Building	Positive Proclamation
115	006	125	Y	Y		Agenda Setting	Relevance of Doctor's Agenda
126	006	324	Y		Y	Checking Understanding	Understanding Doctor's Explanation
145	006	51		Y	Y	Reassurance Strategies	Use of 'Understandable'
154	006	243	Y	Y		Reassurance Strategies	Severity of Ailment
174	006	198	Y			Professional Perspective	Opinion on Emotions
176	006	248	Y	Y	Y	Professional Perspective	Opinion on Emotions
1	007	369	Y		Y	Patient Feelings	Attitude to Ailment
6	007	47	Y	Y	Y	Patient Feelings	Attitude to Ailment
7	007	369	Y		Y	Patient Feelings	Attitude to Ailment
85	007	241	Y			Rapport Building	Offering

101	007	325		Y	Y	Rapport Building	Use of 'I'm sorry to hear that'
113	007	53	Y			Agenda Setting	Relevance of Doctor's Agenda
139	007	101	Y			Information Retention and Attachment of Condition	Support and Future Treatment
146	007	342		Y		Reassurance Strategies	Use of 'Understandable'
158	007	187	Y			Reassurance Strategies	Positive Outlook and Future Support
167	007	180	Y			Professional Perspective	Expert Opinion
#	007	371	Y		Y	Agenda Setting	Expanding the Agenda
15	008	296	Y			Patient Feelings	Desire for Treatment
29	008	353	Y			Patient Feelings	Concerns
39	008	131	Y		Y	Patient Knowledge	Current Knowledge
50	008	131	Y		Y	Patient Knowedge	Desire for Knowledge
55	008	230	Y			Patient Knowedge	Treatment Options
62	008	145			Y	Patient Knowledge	Praise of Patient Knowledge
78	008	65	Y	Y	Y	Lifestyle	Occupation
79	008	72	Y			Lifestyle	Occupation
92	008	77	Y		Y	Rapport Building	Interest Taking
109	008	57	Y			Agenda Setting	Patient Agenda
127	008	83	Y			Checking Understanding	Understanding of Patient's Explanation
130	008	123	Y			Checking Understanding	Understanding of Patient's Thinking and Knowledge
135	008	125	Y	Y		Information Retention and Attachment of Condition	Previous Symptoms and Treatments
160	008	326	Y			Reassurance Strategies	Positive Outlook and Future Support
171	008	307		Y	Y	Professional Perspective	Opinion on Emotions
#	008	307	Y			Comfort	Continuing Comfort
8	009	51	Y		Y	Patient Feelings	Attitude to Ailment
23	009	353	Y	Y		Patient Feelings	Embarassment
47	009	37				Patient Knowledge	Current Knowledge
86	009	238		Y		Rapport Building	Offering
89	009	379	Y		Y	Rapport Building	Praising
93	009	28			Y	Rapport Building	Interest Taking

111	009	339	Y		Y	Agenda Setting	Patient Agenda
114	009	276	Y			Agenda Setting	Relevance of Doctor's Agenda
118	009	364	Y			Agenda Setting	Future Action
123	009	356		Y		Agenda Setting	Future Action
131	009	310	Y			Checking Understanding	Understanding of Patient's Thinking and Knowledge
159	009	139	Y	Y		Reassurance Strategies	Positive Outlook and Future Support
166	009	177			Y	Professional Perspective	Expert Opinion
177	009	241		Y	Y	Professional Perspective	Opinion on Emotions
180	009	272		Y		Professional Perspective	Opinion on Lifestyle
#	009	371			Y	Agenda Setting	Expanding the Agenda
#	009	144	Y	Y	Y	Patient Feelings	Isolation
30	010	140	Y	Y	Y	Patient Feelings	Concerns
33	010	90	Y	Y	Y	Patient Feelings	Concerns
51	010	51	Y			Patient Knowedge	Desire for Knowledge
52	010	90	Y	Y	Y	Patient Knowedge	Treatment Options
63	010	54			Y	Patient Knowledge	Praise of Patient Knowledge
83	010	500	Y	Y	Y	Lifestyle	Personal
90	010	23	Y		Y	Rapport Building	Interest Taking
132	010	309	Y	Y	Y	Checking Understanding	Understanding of Patient's Thinking and Knowledge
140	010	269		Y	Y	Information Retention and Attachment of Condition	Support and Future Treatment
143	010	151 and 158	Y		Y	Information Retention and Attachment of Condition	State then Relate
147	010	117			Y	Reassurance Strategies	Use of 'Understandable'
155	010	120	Y	Y		Reassurance Strategies	Severity of Ailment
156	010	139	Y			Reassurance Strategies	Severity of Ailment
9	011	107	Y	Y		Patient Feelings	Attitude to Ailment
11	011	116	Y	Y	Y	Patient Feelings	Desire for Treatment
13	011	234			Y	Patient Feelings	Desire for Treatment
19	011	328	Y			Patient Feelings	Pain
36	011	175	Y		Y	Patient Feelings	Isolation

42	011	148	Y			Patient Knowledge	Current Knowledge
73	011	80	Y	Y		Lifestyle	General
82	011	500		Y	Y	Lifestyle	Occupation
87	011	33			Y	Rapport Building	Offering
104	011	441			Y	Rapport Building	Positive Proclamation
148	011	360	Y	Y		Reassurance Strategies	Use of 'Understandable'
161	011	324	Y			Reassurance Strategies	Positive Outlook and Future Support
169	011	158			Y	Professional Perspective	Opinion on Emotions
178	011	116	Y	Y	Y	Professional Perspective	Opinion on Lifestyle
2	012	44	Y			Patient Feelings	Attitude to Ailment
14	012	226	Y		Y	Patient Feelings	Desire for Treatment
25	012	300	Y	Y	Y	Patient Feelings	Embarassment
27	012	10	Y			Patient Feelings	Embarassment
34	012	374	Y	Y		Patient Feelings	Concerns
43	012	139	Y			Patient Knowledge	Current Knowledge
64	012	147			Y	Patient Knowledge	Praise of Patient Knowledge
94	012	178		Y	Y	Rapport Building	Agreeing
99	012	299	Y	Y	Y	Rapport Building	Suggesting
105	012	416			Y	Rapport Building	Positive Proclamation
110	012	88	Y		Y	Agenda Setting	Patient Agenda
119	012	397	Y		Y	Agenda Setting	Future Action
134	012	306	Y			Checking Understanding	Understanding of Patient's Thinking and Knowledge
136	012	171	Y			Information Retention and Attachment of Condition	Previous Symptoms and Treatments
149	012	98	Y			Reassurance Strategies	Use of 'Understandable'
157	012	384	Y			Reassurance Strategies	Severity of Ailment
165	012	397	Y		Y	Reassurance Strategies	Positive Outlook and Future Support
173	012	72	Y	Y		Professional Perspective	Opinion on Emotions
#	012	185	Y	Y	Y	Patient Feelings	Isolation
#	012	304	Y	Y	Y	Patient Feelings	Isolation

28	013	11	Y			Patient Feelings	Embarassment
40	013	40	Y			Patient Knowledge	Current Knowledge
54	013	147	Y			Patient Knowedge	Treatment Options
95	013	219	Y	Y	Y	Rapport Building	Agreeing
96	013	316	Y		Y	Rapport Building	Agreeing
98	013	247	Y		Y	Rapport Building	Suggesting
124	013	105	Y		Y	Checking Understanding	Understanding Doctor's Explanation
133	013	311	Y			Checking Understanding	Understanding of Patient's Thinking and Knowledge
20	014	193	Y	Y	Y	Patient Feelings	Pain
21	014	42 and 49	Y	Y	Y	Patient Feelings	Pain
56	014	140	Y			Patient Knowedge	Treatment Options
60	014	78	Y			Patient Knowedge	Treatment Options
68	014	306 and 308	Y	Y	Y	Comfort	Immidiate Comfort
91	014	24	Y		Y	Rapport Building	Interest Taking
100	014	48	Y	Y	Y	Rapport Building	Use of 'I'm sorry to hear that'
120	014	389	Y		Y	Agenda Setting	Future Action
122	014	355	Y			Agenda Setting	Future Action
128	014	42	Y	Y		Checking Understanding	Understanding of Patient's Explanation
26	015	29	Y			Patient Feelings	Embarassment
53	015	188	Y			Patient Knowedge	Treatment Options
74	015	259			Y	Lifestyle	General
97	015	204		Y	Y	Rapport Building	Agreeing
102	015	323	Y	Y	Y	Rapport Building	Use of 'I'm sorry to hear that'
150	015	63	Y	Y	Y	Reassurance Strategies	Use of 'Understandable'
129	016	61	Y			Checking Understanding	Understanding of Patient's Explanation
138	016	96	Y			Information Retention and Attachment of Condition	Support and Future Treatment

From this data, an initial model containing the main categories emerged, and this was used as a basis for the development of the model, including what was taken to the lay focus group (note that the sub-categories were not included on this model, as it was felt that it may be too much information and too confusing for the lay focus group to absorb and understand in the timeframe given for the focus group. Figure 3 summarises the initial findings from the data:

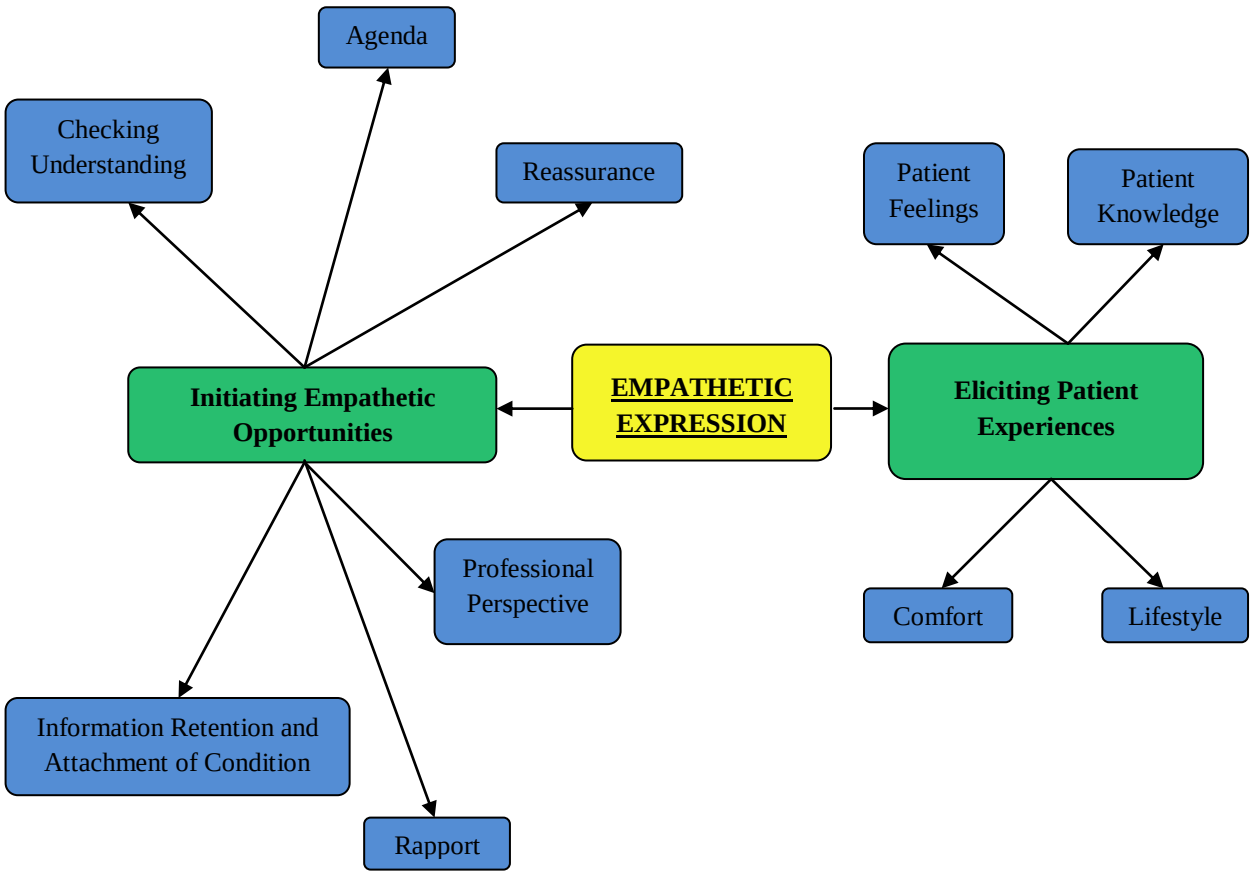

Figure 3. Interactional paradigm displaying initial categories derived from the data.

Fifth Phase

By this point, as discussed above, an initial framework had emerged from the data. However, this was still very much considered an initial framework. As a method of further validation of the framework, PPIRes (Public and Patient Involvement in Research Group) were consulted during a two hour focus group. This was predominantly to observe whether they as a group could map their perceptions of how empathy is expressed onto the framework. The theory behind this was that if PPIRes could map all of their perceptions onto the framework, then it would suggest evidence for a theoretically saturated model; if they could not, then it gave an opportunity to adjust and improve the model, thus enhancing validity.

7.2. FOCUS GROUP ANALYSIS

PPIRes were first asked to produce definitions of empathy and discuss these as a group. This allowed the focus group to function more as a team, and acted as a prelude to the main task. The idea of treating PPIRes in this manner, rather than a set of individuals had two advantageous effects. Firstly, it gave the participants a broader view of empathy, and secondly it correlated well with the PPIRes mandate that they are a patient group, rather than a group of individuals (Hainstead [PPIRes Co-ordinator], 2013: personal communication).

The following section draws on examples from the transcript of the focus group discussion (note that the participants are numbered as P1, P2 etc, and AM refers to the researcher). In the first instance, the focus group were asked to write down a brief definition of what they thought empathy involved. Their definitions were as follows:

> *P1: 'Understanding patients and their feelings, and having a connection' (34).*
>
> *P2: 'Empathy involves body language, the words used. Tone delivered in. Physical interaction from the doctor's face.*

Looking at the patient. Offering a chance for questions. Avoiding closed questioning or answering' (31-33).

P3: *'An understanding of what is said and felt. Showing this understanding by words and gestures' (35-36).*

P4: *'Empathy is the feeling I've been understood; listened to, without judgment or without the doctor being irritated by me' (37-38).*

The term 'understanding' was present in three of the four participant's definitions, and in two instances, this was specifically related to feelings. P2 and P3 both listed the words and non-verbal behaviour used by the doctor as an aspect of empathetic expression, whereas P1 and P4 focused more on the macro aspects of empathy, with the connection between interlocutors, refraining from judgement and not becoming visibly irritated by the patient all being linked to empathy. Regarding the understanding of the patient, there was a particularly illuminating sequence of interaction between the focus group facilitator (P5) and P1 when the definitions had been listed, which led to a revision of empathy involving the understanding of the patient:

P5: *My description was 'being able to put yourself in the position of another person, being able to appreciate the feelings...*

P1: *But how can you appreciate the feelings.*

P5: *Without being...*

P1: *No.*

P5: *Condescending.*

P1: *Yeah, but you don't know how I'm feeling; you can't imagine how I'm feeling.*

P3: *I think you can try actually (127-134).*

In this instance, P1 confronted P5's definition involving the appreciation of the patient's feelings, where P1 argued that you can never truly understand what another

person is going through. This, however, was clarified by P3's comment that while it may be impossible to fully comprehend another's internal state of mind, it is the willingness to try which is an act of empathy in itself. It could be argued that while the complete comprehension of another's state of mind is impossible, it is feasible for the doctor to obtain at least some degree of understanding relating to the patient's thoughts and feelings. By asking the right questions, listening to the answers, and responding in an appropriate manner, the doctor can build up a more complete picture of the patient's cognitive and affective state. Through doing this, at the end of the consultation, even if the medical student does not have a holistic understanding of the patient's thoughts and feelings, they will still have more of an idea as to what the patient is going through, compared to what they knew at the beginning of the consultation.

Following from this process, PPIRes were then asked to watch two of the 16 recorded consultations. The chosen consultations were 003 and 010, which were selected due to having a male student with a female role-player in 003 and vice-versa in 010. It was also a result of consulting with two of the thesis supervisory panel; it was agreed that (based purely on the feel of the consultation) that 003 felt like a very empathetic consultation, whereas 010 was less so.

The task for PPIRes here mirrored that which had been completed previously by the Researcher, Student and Role-player with the use of **FORM 3E w**here aspects of the consultation were coded as empathetic. However, instead of using the form, PPIRes were instead asked to write their descriptions of the acts on post-it notes. They were then presented with a simplified version of the categories derived from the data which were presented on an A1 piece of cardboard in the form of a mind map. They were asked to stick the post-it notes onto the relevant categories. The group had no problems finding categories to place their post-it notes, and this further confirmed the theoretical saturation of the data. However, the group did also discuss other aspects which were external to the consultation, and this led to the development of an additional main category related to external factors that can influence empathy in the consultation. These issues are discussed below.

7.2.1. Patient Familiarity with the Mode of Consultation

Many of the points raised by the focus group are discussed at greater depth in later chapters, as they corresponded well to the interactional framework which evolved from the data. However, there were other features highlighted by the focus group which did not relate to the interactional elements of the framework, but may still be regarded as a vital constituent involved in empathetic interaction in the consultation. For example, the potential gulf in consultation experience was raised in the following examples:

> *P4: 'They really don't know what their life experiences or where they come from. And I think they've just got to be open and just sort of be a blank page for the patient to write on' (51-54).*

> *P1: 'He needs to appreciate he may well be dealing with this particular case five or six times a day. It's your first time. That's important' (54-55).*

Particularly salient in the second example, it seems that the focus group member is emphasising the importance for the doctor to consider not just the emotional state of the patient, but also the patient's ability to deal with a situation such as going to the doctor. It could be interpreted that this relates to the idea that if a patient goes to see the doctor on a regular basis for a recurring illness, they will become more familiar with the consultation process, and thus the doctor should treat them as such. However, the doctor must also remember that some patients rarely attend a practice, and as such, there is a level of knowingness about the institutional practice which may be missing, hence the patient may be less familiar and more nervous about the consultation process. Evidently, the advice for the doctor to consider each patient as a blank page is more useful when meeting a patient for the first time, and in subsequent visits the doctor may build on the previous information given to them by the patient. Failure to build on this information may, in fact, be interpreted by the patient as an apathetic act.

7.2.2. Administrative Importance

In addition to the above, the focus group also discussed a number of issues which they deemed to be related to empathy; however these were not a part of the consultation, but rather to do with the administrative side of the healthcare process. Take the following extract for example:

P2: *It actually goes a bit further back than that because my wife has blood tests for regular bits and pieces in terms of the doctor's letter just said 'the doctor wants to see you' and we couldn't go for a week so you have a week thinking 'what is wrong'?*

AM: *Okay. So that's perhaps more on the administration side.*

P2: *Yes. But it's still linked in. Because you've got the tension before you get there.*

AM: *And would you say that that can affect the way you experience um or the rapport with the doctor to start off with.*

P2: *Yes because she was worried before she went in. And when she got in she was obviously terrified (11-19).*

Here, the focus group highlighted a potential influencing factor in the consultation, which, when analysing empathy in interaction, is often overlooked. Another element which was also not apparent in the data from the simulated consultations was the use of the patient's notes:

P2: *I would say that if the doctor's actually read the patient's notes, he would have a little bit of understanding of how they were feeling. In-so-much as you know major events in their past. Then they might understand if they have anxiety or not (41-43).*

Therefore, while empathy is an essential part of the consultation process, creating the conditions for the empathetic process begins prior to the consultation, and often involves other elements, such as the letters sent to patients, and the interaction with the administrative staff in a GP's surgery.

7.2.3. Formality in the Doctor-Patient Relationship

Another aspect discussed by the focus group which is also not a direct part of the empathetic interactional process, but is nonetheless vital to the overall constitution of it, involved the formality and professionalism of the doctor, particularly in the initial part of the consultation. For example, P1 noted:

> *P1: But you walk in and the doctor doesn't even look at you. I mean that's bad enough and shake your hand (66-67).*

Knowing whether to shake hands is becoming more and more complex in a fast-growing multicultural society. While traditionally in the United Kingdom, shaking hands is seen as a polite and formal method of greeting someone, in other cultures, shaking hands is avoided for a variety of reasons, ranging from hygiene to religious preferences. Hence, this dilemma means that a doctor or medical student must make a judgement with little or no information about the patient's preferences to go on. If they do not shake hands, they may insult the patient; if they do shake hands, they may insult the patient. The doctor could guess as to whether the patient wishes to shake hands; however, this would likely be based on stereotypical assumptions (age, gender, ethnicity etc), and goes against the idea of treating the patient as an individual with an individualised agenda. In consultation skills training, some of the tutors (including myself) advocate a 'don't shake the patient's hand unless they offer it to you first' protocol. While this minimises the threat to the patient's face, it can often come across as awkward and reluctant to a patient who is expecting a handshake. This said however, another member of the focus group dismissed the significance of the handshake in favour of the formal introduction:

> *P3: I think the introduction is more important for me than the handshake. I think to say, you know I'm doctor martin, I think particularly if you're going to examine me, I find that more important than shaking hands (87-89).*

It could be argued that while a handshake is deemed important by many patients in the United Kingdom, other aspects of the introduction, such as the use of the doctor or medical student's full name and making eye contact with the patient is equally, if not more, influential in the empathetic process.

Another aspect relating to formality and professionalism was referred to in the following extract:

> *P2:* *It is important that the doctor acts professionally. If you're telling someone with cancer that they've got three months to live, it wouldn't help me if the doctor then burst into tears. They've got to somehow remain a little detached and professional, but still be sympathetic and empathetic (145-149).*

In this instance, the focus group participant appears to be referring to the idea of the doctor simulating the patient's thoughts and feelings, but maintaining what Carl Rogers referred to as 'the as if condition' (Rogers, 1959: 210), namely, their ability to understand the emotional state, but not take on that emotional state themselves.

7.2.4. Time Constraints

The focus group raised the issue of time as being associated with the opportunity for empathetic expression. One panel member asked:

> *P3:* *Do they have pressures with time? Because I'm just thinking, one of the things with saying tell me more, is I've got to get this done in time you know. And I think that's quite hard. So it's a very delicate balance isn't it? Between being empathic, and getting the job done (310-313).*

The merger of being empathetic and 'getting the job done' is perhaps one of the more complex issues with regard to all consultations, and is certainly a common complaint from medical students, who often claim that it is impossible to get all the

information that they need and be empathetic within a ten minute timeslot. It stands to reason that the more time a doctor has to spend with a patient, the more opportunity they have to develop a rapport and express empathy towards them. However, in order to see the large number of patients who come to a doctor, and to operate within the confines of a set budget, time must be restricted. P2 divulged an administrative strategy which could assist with this, when they stated:

> *P2:* *So you've got to be aware of the time, but you've also got to be flexible and just allow people that minute of two if they need it. The whole way through my surgery, there are notices you have ten minutes time but if you need more, we'll give it to you. To help patients understand (330-333).*

From speaking to the focus group during the breaks, and subsequently asking friends and family about time constraints for doctors, many were surprised to discover that they were only allotted ten minutes in a standard consultation. In one extreme case, someone thought that when they went to the GP they had a 50 minute consultation. Therefore, it seems the problem is not simply for the doctors to solve with adept consultation skills, but also there is a necessity for patients to be educated with regard to what to expect from a consultation.

Figure 5. incorporates the above findings into the interactional paradigm pertaining to how empathy was perceived to be expressed in the research.

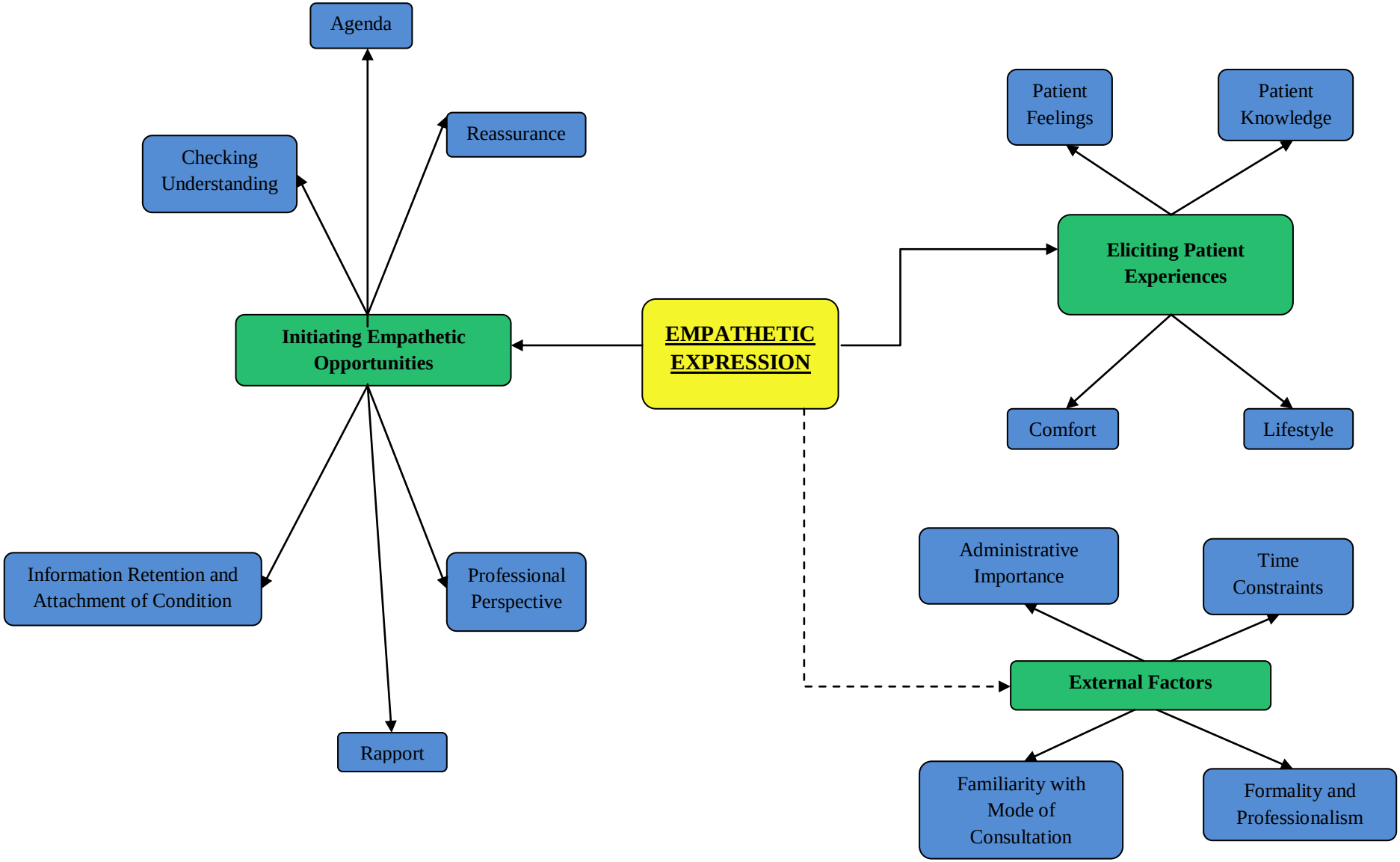

Figure 4. Interactional paradigm displaying initial categories derived from the data and focus group.

7.3. GESTURE AND NON-VERBALS

Non-verbal behaviour is to be addressed separately in this chapter, due to its infrequent coding in the data, as the majority of the coding was about the language used, rather than the gestures. It is unclear why this is, and reasons for which are discussed later in the thesis, but it should be made clear here that no cues were given to the coders to focus on verbal, rather than non-verbal, features. Only a small amount of the coding involved non-verbal behaviour or gestures. This is an anomalous finding, as many of the participants in this study placed less emphasis on the role that the linguistic aspect played in the expression of empathy. For example, one member from the focus group was keen to point out that they thought 'often it's what is not said that is more to the point I find'. Moreover, after the coding session had been conducted with participant 010, she came to talk about the study afterwards, and claimed that she thought that most of her empathetic expression came from her gesticulation; however, her coding did not reflect this, with over 90% of it being related to the language used.

It could be argued that the non-verbal behaviour was coded so infrequently because it was not deemed to be involved in the empathetic process. However, judging from general comments made throughout the duration of the study, it appears that many people place a firm emphasis on the non-verbal expression of empathy. Therefore, although the non-verbal aspect of empathy is deemed important, the participants' ability to recognise specific acts involved in its creation of empathy was limited, and this may be because these acts may be unconsciously perceived. The inclusion of user involvement in this study appears to require enhancement with regard to the method of coding the non-verbal aspect of empathy. This said however, there were still sections in the coding which did relate to the non-verbal, although these are more concerned with the general elements of the consultation (described below), rather than specific non-verbal techniques associated with empathetic expression. Furthermore, these codes generally occurred at the beginning of the consultations, and were left largely ignored throughout the majority of the remaining interaction.

The non-verbal techniques which were coded as co-occurring with expressions of empathy were nodding, eye contact, smiling, and laughing. Coding of nodding tended to occur at the beginning of the consultation, particularly during the golden minute, and this was likely a form of active listening/back-channelling[7] from the medical student to encourage the simulated patient to provide as much information as possible, and also give the simulated patient ample opportunity to provide the information they deemed most relevant. Hence this could be seen as a method of enabling empathetic interaction, where the simulated patient's agenda takes preference in the interaction.

Eye contact was also a technique frequently coded near the beginning of the consultation, and again, this could be linked to the concept of active listening, and the student attempting to gather further information from the simulated patient. Since these techniques were both deemed to co-occur with verbal expressions of empathy, it could be considered that empathy is an integral aspect of the golden minute itself, with the non-verbal expression of such aiding in the information gathering process.

Other non-verbal behaviour coded as expressing empathy was for the student to smile and, on occasion, laugh, with the simulated patient. Smiling occurred predominantly at the beginning of the consultation, whereas laughing was, unsurprisingly, context specific, and only occurred where the opportunity arose. One specific example of laughing occurs in 011:

[7] The term back-channelling originates from the field of linguistics, and here refers to the way in which one person shows they follow and understand what another is saying (e.g., uhu, okay, mmm).

[011]

178 Patient: [nobody ever
179 talks about [them though do they

180 Student: [no they don't but

181 Patient: i don't know anyone (.) well £i-i-i
182 probably do↑ but i no one hhh.£ (.) ever
183 talks about them

184 Student: £hhh. yeah (.) so don't be embarrassed at
185 all about them (.) um (.) they're very
186 common and um (.) they're caused by >so
187 you've got these these< veins

Here, it seems that the simulated patient uses laughter to cover their embarrassment surrounding the haemorrhoids, and the medical student mirrors this laughter while reassuring the simulated patient that haemorrhoids are a common ailment. In this instance, the medical student mirroring the simulated patient's laughter was deemed an empathetic act; however, this is not always the case – especially when laugher is used to cover embarrassment. An authentic ethnographic example, observed by the researcher, occurred in a speech therapy consultation, where a middle-aged male who had run his own business attempted to cover his embarrassment and frustration at his loss of some speech capacity through laugher. The therapist mirrored this laughter, unaware of the patient's concealment, which led the patient to become very angry. Hence, it is important for any health professional to judge the situation carefully, and consider that some non-verbal behaviour may be an attempt at concealing the patient's true feelings.

While the method used here allowed the participants to code the more apparent empathetic non-verbal behaviour, specific instances of it were largely ignored or omitted from the coding. Hence, it may prove useful in future research to remove the language from the screening of the consultations, so participants are obliged to focus on gesture and non-verbal behaviour, although the extent to which these two media

can be separated and still maintain the same effect must be considered. As an empathetic device in itself, further research needs to be conducted into the non verbal aspect of perceived empathetic expressions. However, in addition to the above discussion, non-verbal behaviour did augment some of the empathetic expressions which were expressed verbally, and these are touched upon in the following chapters.

Figure 1Figure 5 incorporates the above findings into the interactional paradigm pertaining to how empathy was perceived to be expressed in the research.

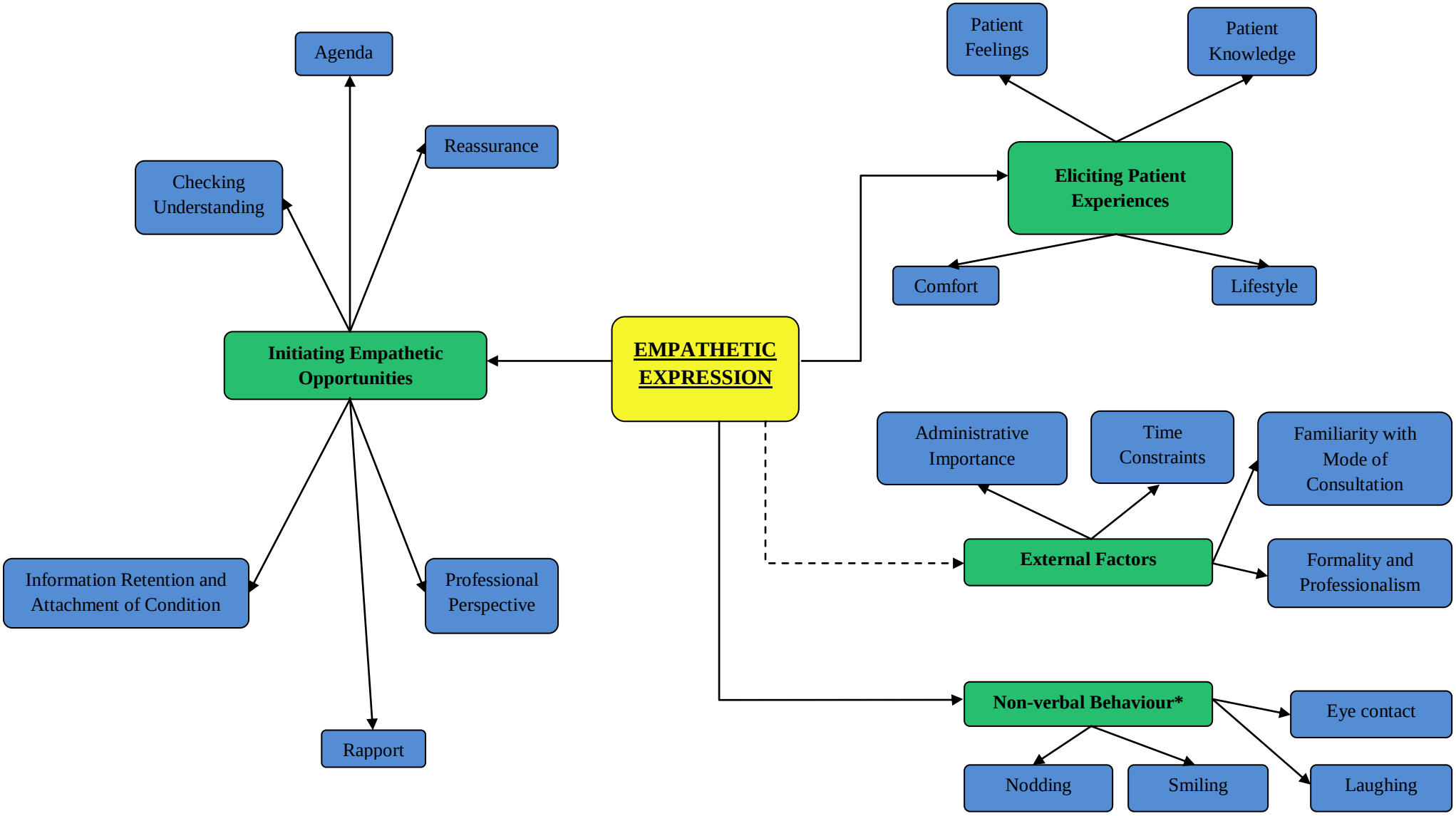

Figure 5. Interactional paradigm displaying initial categories derived from the data (including non-verbals) and focus group.

CHAPTER EIGHT: ELICITING PATIENT EXPERIENCES

8.0. INTRODUCTION

One of the primary findings which emerged from the member coding showed that a medical student's attempt to demonstrate their understanding of the patient's thoughts, feelings and experiences was a behavioural correlate of empathetic expression. This involved the medical student's attempt to understand the simulated patient's thoughts and feelings, and then reflect these back to the simulated patient through a communicative paradigm. Importantly, it was the attempt to understand the simulated patient which seemed to be the impetus for the empathetic act, rather than the accuracy of the communication itself, and this is concurrent with the findings from the focus group. Four main categories were identified, and these pertained to the patient's feelings, knowledge, comfort and lifestyle. The following two chapters draw from examples in the transcripts, with the following layout of the examples from the transcripts: the number in round brackets refers to the example number (these are referenced in Table 5), the square brackets refer to the transcript/consultation number, the numbers at the side of the quotes refer to the line numbers in the transcripts, and the arrow at the side of the quote relates to the starting section of the transcript which was coded as empathetic by one or more participants (further details of this can be found in the table).

8.1. PATIENT FEELINGS

Considering the thoughts and feelings of the simulated patient was coded as a vital aspect in empathetic expression. This involved the medical student finding out about the simulated patient's attitude to the ailment and their desire for different types of treatment. Moreover, a deliberation of the simulated patient's emotions – in this case, pain, embarrassment, concerns and isolation – were also key in the empathetic process.

8.1.1. Attitude to Ailment

Participants coded expressions of empathy associated with the medical student attempting to understand the simulated patient's attitude towards the ailment they had. The most obvious technique for investigating this was for the medical student to simply ask about the simulated patient's thoughts and feelings directly (note that the arrow at the side of the examples denotes the exact part of the extract which was coded by the participants as being empathetic):

(1) [007]:

364 Student: um (.) and obviously we want to do
365 something (.) we want to get you out of
366 pain as quickly as [we can

367 Patient: [yeah (.) yeah

368 Student: as well (.) um because it's not ideal (.)
→ 369 at the moment (.) what are your thoughts

(2) [012]:

37 Student: and you recently had (.) haemorrhoids
38 diagnosed

39 Patient: that's it °yeah yeah° they said they were
40 grade two

41 Student: grade two yeah (.) okay so (1.0) just from
42 your perspective (.) would you like to
43 bring me up to speed about what's been
→ 44 going on (.) what's been going through
45 your head

(3) [004]:

220 Student: well um there are treatment options
221 available (0.5) erm (.) depending urm
222 which surgery depends on which options as
223 well (0.5) um there's treatments that can
224 just help towards your symp↓toms so things
225 just like the pain (.) and then there's

226 also treatments that aim to cure [they aim
227 to um get rid of them[

228 Patient: [right
229 [okay

→ 230 Student: um (.) what are your feelings about (.)
231 [those

(4) [003]:

43 Patient: so i'm i'm just here today to sort of
44 discuss (.) what the next step is really

→ 45 Student: okay (.) okay (.) urrm (.) a::nd are you
46 feeling okay about (.) having having a
47 haemorrhoid

It could be argued that this is linked to the notion of positive face (desire to be accepted by others), as for the simulated patient's wants and needs to be accepted by the medical student, they must first be understood. Hence by the medical student asking these questions outright as seen above, they are offering the simulated patient the opportunity to achieve this, and thus it acts as a prelude to positive face maintenance. Once the student has elicited this information from the patient, they will have a better idea of the individualised patient's wants and needs, and thus be able to build the consultation around this. In related examples, rather than asking the simulated patient directly, the medical student would presuppose the patient's feelings:

(5) [005]

60 Patient: but um (1.0) you know i-i work from home
61 and er (.) i work with my partner but
62 >it's just it's just< really affecting me
63 quite badly it's um

64 Student: mmm

65 Patient: quite demoralising you know

66 Student: yeah i can i can see that you you don't
→ 67 seem very (0.5) you seem kind of (.) fed
68 ↑up with it ↓all

(6) [007]

41 Patient: um (.) and er (.) >the the< the doctor at
42 the hospital said (.) they were
43 haemorrhoids

44 Student: okay

45 Patient: and um (.) but it has got to the point now
46 where it's really really painful

→ 47 Student: i um (.) yeah i can imagine it's not a
48 very nice (0.5) thing to have so (.) and
49 now you're thinking about the next step
50 for (.) some sort of treatment is that
51 right

(7) [007]

364 Student: um (.) and obviously we want to do
365 something (.) we want to get you out of
366 pain as quickly as [we can

367 Patient: [yeah (.) yeah

368 Student: as well (.) um because it's not ideal (.)
→ 369 at the moment (.) what are your thoughts

370

Here, the medical student is essentially approximating the simulated patient's thought process, and then verbalising their understanding back to them. Thus the empathy here comes from simulating what it is like having the condition. This allows the simulated patient the chance to correct or adjust the medical student's opinion, while at the same time making the simulated patient feel understood. Another example of this can be shown with the medical student's use of the modal verb (Crystal, 2004: 77) 'must':

(8) [009]

46	Patient:	um (.) they said i've got grade two (.)
47		haemorrhoids (1.0) um (.) er (.) really i
48		(.) must get something done about that (.)
49		y'know i don't know what °to do° (1.0) i
50		just can't go on like this really
→ 51	Student:	it must be really >affecting you< as well
52	Patient:	i-it does you know i have to sit down a
53		lot [um for my work

(9) [011]

102	Patient:	i-it (.) it sort of just makes my day a
103		bit easier
104	Student:	okay
105	Patient:	but by no means (.) comfortable [really
106	Student:	[alright
→ 107		(.) okay (.) that must be (.) really (.)
108		frustrating for you=

The use of the modal in these instances indicate that the speech acts (Austin, 1962) are as close to directly stating 'it is bad', while still leaving room for the simulated patient to adjust the statement. Thus, the above examples demonstrate how the medical student can express empathy to the simulated patient through revealing what they think the simulated patient is experiencing, while leaving their interpretation open to alteration from the simulated patient.

8.1.2. Desire for Treatment

The medical student attempting to gauge the simulated patient's preference for various treatments was also perceived as an empathetic act. In a number of cases, the medical student would empathise with the simulated patient's desire to get the ailment treated and/or cured:

(10) [003]

279 Patient: so (.) and it and it is affecting (0.5)
280 you know because it makes life so
281 uncomfortable

→ 282 Student: sure sure (1.0) so you really want to get

283 Patient: i really want to get this sorted out (.)
284 yeah

(11) [011]

109 Patient: =well it is because you can't (1.0) you
110 can't really concentrate on what you're
111 doing at work because really all you're
112 ever thinking about is [the pain that
113 you're in

114 Student: [no

115 Patient: you know

→ 116 Student: i can understand why you'd really want to
117 (.) get it >sort of< sorted=

(12) [004]

84 Patient: i mean it's (.) y'know (.) sometimes i
85 stand up cos it's (.) it's so awf (.)
86 £it's so awful£ and um it would be great
87 if i could get back to normal

88 Student: of course so it's having quite an impact
89 on your life interfering with ↑work and

90 Patient: definitely yeah

→ 91 Student: so i can see we (.) ought to get this
92 sorted for you

(13) [011]

226 Student: [yeah (.) yeah (.)
227 do you notice if they're worse when you've
228 got (.) more constipation than

229 Patient: i don’t know if they’re worse or better to
230 b- (.) i think both sort of seems to >sort
231 of< bring them on

232 Student: okay

233 Patient: for some reason

→ 234 Student: yeah (.) definitely sounds like something
235 you need to look i[nto

Similarly to the examples concerning the simulated patient’s attitude to the ailment, these utterances involve the medical student presupposing what the simulated patient wants, and verbalising this back to them. This may seem obvious in a medical consultation, as all patients go to the doctor for some sort of help; however, through the medical student verbalising this, they are demonstrating that they have at least tried to understand the patient’s thought process, which links to the comments made by the focus group discussed previously. It could be argued that this acts as a precursor to positive face enhancement, as for the wants and needs of the patient to be desirable to the other (Brown and Levinson, 1987), the medical student must first understand the patient’s desires, and this method of gauging the patient’s treatment preferences can help to achieve this. By verbalising the understanding of these desires, the simulated patient may not only feel understood, but also that their wants and needs are desirable to the medical student as well, and this is likely to be the reason why this technique was coded as being empathetic.

Further empathetic instances were coded involving the medical student asking about the simulated patient’s preferences regarding treatment options:

(14)[012]

221 Patient: well y’know i’m so frustrated by it
222 obviously i want to get it sorted out but
223 i don’t want anything (.) well y’know d’y
224 if you just tell me what the options are
225 and i’ll (.) make a decision based on that

→ 226 Student: so (.) are you a bit reluctant about
227 having surgery

(15)[008]

292 Student: um and those are the kind of things you
293 can help to try and prevent (0.5) um
294 haemorrhoids (.) coming

295 Patient: okay

→ 296 Student: appearing (.) does that (1.0) do any of
297 those options the treatment options that i
298 said do they (.) cos you seem [quite
299 desperate ( )

(16)[006]

396 Student: so those are >sort of< some of the basic
397 measures you can take (.) another thing is
398 (.) as we've said because it's very
399 unassertive to put strain on (.) you want
400 to try and avoid strain (.) so try not to
401 spend >sort of< too long on the toilet and
402 just to try and go regularly and the way
403 you need it not to hold onto it (0.5) so
404 y'know if you can reduce the strain that
405 will also reduce all the pressure (.) and
406 so that the pres the pressure in the back
407 makes it worse

408 Patient: mmm

→ 409 Student: so these are all things that you can do
410 yourself (.) um i know that >sort of< you
411 you mentioned you wanted a solution and
412 you wanted to look at >sort of< um (.)
413 >sort of< more (0.5) long term (.) yss
414 more (.) permanent treatments

These involve the medical student gauging the simulated patient's preference to treatment options in a more direct manner, and this further demonstrates the medical student's desire to understand the simulated patient's thought process. For instance, in example 14, line 226, the medical student implies that they are understanding the simulated patient's reluctance for surgical procedures, likely due to them considering that the simulated patient may be frightened and intimidated about the potential pain

and dangers associated with the procedure. Moreover, in example 16, line 413, the medical student exhibits an understanding of the simulated patient's preference for permanent, rather than temporary, treatments. Therefore, it can be seen that empathy may be expressed through the medical student gauging the simulated patient's desire for treatment within the consultation, and then verbalising their insight on the internal cognitive processes which they believe the simulated patient is experiencing.

8.1.3. Pain

The manner in which the medical student approached the discussion of pain was another topic deemed to be involved in empathetic expression. The following examples demonstrate how the medical student attempted to assuage the severity of the pain involved with various treatment options:

(17) [004]

327	Student:	yeah (2.0) um in terms of (.) um t-ss
328		(1.0) curative treatments (
329		) um one is that you can have an injection
330		(.) actually into the haemo↑rrhoid
331	Patient:	sounds a bit
→ 332	Student:	which always sounds a bit
333	Patient:	that sounds ha::rsh

(18) [002]

229	Student:	that's good (.) so if we move on to um (.)
230		the interventions that we can do (1.0)
231		there's various things that you can try
232		errrm such as um they can inject a
233		chemical (.) into the haemorrhoids
234	Patient:	ooorrhhhh
→ 235	Student:	which um (.) it sounds quite nasty but
236		it's (0.5) it is done on an outpatient
237		basis (.) it won't involve a stay in
238		hospital

(19) [011]

322 Student: um (.) and then there is um (.) some more
323 sort of more kind of (.) permanent
324 treating

325 Patient: mmm

326 Student: sort of things we can look at (.) um (0.5)
327 they can inject (0.5) into the haemorrhoid
→ 328 (.) which sounds painful [but (.) it
329 shouldn't ↑be

The use of the word 'sounds' implies that although the previous statement about the severity of the pain may have come across as extreme to the simulated patient, there is an element of misinterpretation on the simulated patient's part. This is further enforced in examples 18, line 235, and example 19, line 328, where the conjunction 'but' is used to indicate that the previous statement needs to be qualified for its intended meaning. Thus, the use of 'sounds' and 'but' both act as qualifying methods of reassurance for the simulated patient when talking about pain. The medical students' consideration of the simulated patient's individual experience of the pain further enhanced the empathetic expression in the consultation:

(20) [014]

190 Patient: but i'm only a grade two this is awful

191 Student: i know so imagine (.) they can be more
192 painful but they affect everybody slightly
→ 193 differently (.) doesn't take anything away
194 from how painful [yours are

(21) [014]

37 Patient: and um (1.0) and so basically today i've
38 just come back to have a talk (.)
39 hopefully have a chat about y'know what
40 the next steps are [really

41 Student: [okay (1.0) okay (.) um
→ 42 (.) so for the last six months (.) you've
43 been having pain

44 Patient: well it was the bleeding that worried me
45 (.) more than anything else but over the
46 last six months since then (.) it's just
47 been (.) excruciating i can't tell you

48 Student: ah i'm sorry to hear that (1.0) uh is
→ 49 anything that make it better >or worse< at
50 the time

In the first example, the medical student is demonstrating to the simulated patient that they are considering their pain on an individual basis, thus making the consultation more patient-centred. Moreover, in the next two examples, the medical student is investigating the simulated patient's pain further, with specific questions about the simulated patient's lived experience of the illness. Hence in these examples, it is the exploration and individualised consideration of a simulated patient's pain which is deemed to be linked to empathetic expressions, rather than a generic description of pain which is hypothetically associated with the ailment.

8.1.4. Patient's Embarrassment

There is a level of embarrassment associated with haemorrhoids, and the medical student's ability to deal with this in an adroit and professional manner was coded as an empathetic act. Within the cultural context of this simulated consultation, haemorrhoids may be seen as a taboo subject, as they occur in a private part of the body and also can have sexual connotations, and this is reflected in the medical students' language when speaking to the simulated patient:

(22) [003]

348 Student: um (.) you're in good company (.) fifty
349 percent of the uk population will have
350 haemorrhoids at some point in [their lives

351 Patient: [really cos
352 you no one ever talks about it so you
353 never (0.5) you never hear

→ 354 Student: yep (.) yeah (.) well it's u awkward

355 conversation=

(23) [009]

160 Student: so that could be (.) one of the reasons

161 Patient: °°okay°°

162 Student: °why you developed this problem° (0.5) so
163 (.) um (.) it's a relatively common
164 problem that happens to a lot of people
→ 165 (.) and obviously we don't (.) often like
166 to talk about things like that [and so

In these examples, the medical student is demonstrating their understanding that the topic of the conversation is awkward, and not something which is openly discussed in society. However, since it is causing the patient a problem, it is a topic which must be discussed in order to address the problems experienced. In one case, the embarrassment was directly counter-acted by the medical student:

(24) [005]

39 Patient: uh (.) and that's (0.5) that's enough in
40 itself but then to have this as well you
41 know and it's all quite embarrassing °you
42 understand°

→ 43 Student: hm well there's nothing to be embarrassed
44 about really

Moreover, in another example (example 25) where there was potential cause for embarrassment and no obvious way to avoid it, the medical student prefaced the speech act (Austin, 1962) with a warning to the simulated patient on line 300 before going on to discuss the potentially embarrassing topic on line 305:

(25) [012]

299 Student: okay (.) um (.) so the other thing is >and
→ 300 this might< be a bit embarrassing but (.)

301 it's just us here so you don't have to
302 feel embarrassed at all

303 Patient: okay

304 Student: and it's completely natural (.) once you
305 go to the toilet (.) when you get the urge
306 to go

307 Patient: yeah

308 Student: don't resist the temptation (.) to hold it
309 in >i mean< don't hold it in

In another example (example 26), the medical student overlaps with the simulated patient on lines 28-29, when they anticipate the simulated patient is embarrassed about using the term 'haemorrhoids':

(26) [015]

23 Patient: um >what uh well< i was hoping today (.)
24 that we could talk about (.) about um
25 >y'know< what's gona happen next after
26 [the tests i had at the hospital

27 Student: [sure (0.5) okay (.) okay

28 Patient: about the (.) the the um [°°haemorrhoids°°

→ 29 Student: [the problems

30 Patient: yeah

Here, the overlap and use of the term 'problems' instead of 'haemorrhoids' lessens the embarrassment for the simulated patient, as it acts as a euphemism. The use of euphemistic language was a method used to avoid embarrassment while discussing taboo topics. Psycholinguist Steven Pinker claims that 'the common denominator of the content of swearing [hence taboo language] is an emotional charge that people would rather not have running through their minds at the drop of a hat... because speech perception is automatic, uttering a taboo word can force a listener's mind to go in a direction it ordinarily prevents itself from going in' (Pinker, 2008). Hence,

the language used in many cases to describe faeces was carefully crafted by the medical students; for example, 'poos' (014, line 134), bowel movement (010, line 75; 011, line 393), and 'going to the toilet' (014, line 68). Here, it can be seen that the description of faeces to the simulated patient is either colloquial (poos), or formal (bowel movement, going to the toilet), thus alleviating the taboo aspect to a certain extent. Interestingly, instances where the medical students who used more formal technical terms such as 'faeces' and 'stool' were not rated as empathetic within the coding, perhaps suggesting that this level of formality is expected by the patient in all cases. It could be argued that the use of more formalised lexis to describe taboo topics creates a barrier between the medical student and the simulated patient, thus altering the empathetic ethos of the consultation. Unsurprisingly, more dysphemistic terms (such as 'shit' and 'crap') were avoided altogether. The use of euphemisms also occurred with the general descriptions of the ailment. For example:

(27) [012]

8	Student:	a::nd your GP doctor ma:rtin (.) has just
9		asked me to come and have a chat with you
→ 10		today (.) cos i understand you've (.) had
11		a <bit of news recently>
12	Patient:	well i-i-i had some kind of (.)
13		sigmoidoscopy at the hospital yeah

(28) [013]

7	Student:	[i've been asked to speak to you by your
8		doctor (0.5) is that alright↑
9	Patient:	uh yeah that's fine yeah
10	Student:	okay (.) so what i've been told is that um
→ 11		(.) you've had some (.) haemorrhoids down
12		below
13	Patient:	yeah

Again, these examples show the medical student to be avoiding talking directly about the associated side effects and affected areas with regard to haemorrhoids, thus

saving the simulated patient's negative face (Brown and Levinson, 1987): not impeding their wants and desires by embarrassing them through the discussion of their ailment. It may be logically assumed that the medical student understands that the simulated patient does not want negative connotations in their mind.

8.1.5. Concerns

Exploring the patient's concerns is listed as an important factor in the Calgary/Cambridge model, and was also coded as a form of empathetic expression in the data. The most prominent concern for the simulated patient in the chosen scenario was the possibility that the bleeding from the back passage could actually have been a side-effect of bowel cancer, rather than haemorrhoids. The simulated patients frequently gave both verbal and non-verbal cues that this was a concern. However, in the following example, there was a dispreference for using the word 'cancer' directly, both on the part of the patient, and medical student:

(29) [008]

348 Patient: i can't (.) i mean sss (1.5) obviously
349 when you see blood in your stools it's
350 (1.0) it's quite concerning about [what
351 that might be

352 Student: [yeah of
353 course (1.0) yeah

354 Patient: you think that might be anything else °at
355 all°

→ 356 Student: er-you said it's fresh ↑blood (.) didn't
357 you (.) and it's very red

358 Patient: yeah=

359 Student: =on the tissue (.) that and they've looked
360 inside already (.) um and they've found
361 haemorrhoids (.) which again (.) and
362 they've (.) y'know (.) diagnosed that so
363 it's very unlikely that you'd have any
364 other (.) problem cos it's fresh blood (.)

365 but they'll give you advice on (0.5) um if
366 you're still getting symptoms to come back
367 and have more investigations

368 Patient: yeah

It can be seen that the patient is being purposely ambiguous, due to the negative connotations associated with the word 'cancer' and the student subsequently copies this practice throughout the sequence. Starting on line 348, the patient stops themselves from using the word 'cancer' demonstrated by the 'sss' and following pause of 1.5 seconds. They then go on to discuss the physical symptoms which have occurred: 'blood in your stools', before pausing again '(1.0)', and finally acknowledging that this is something that has been concerning them. It is unclear whether this ambiguity is for the simulated patient's benefit, or the student's, but by not using the term, the simulated patient is preventing the medical student from experiencing the negative connotations which co-occur with the word, and also guarding themselves against this to an extent. In doing so, they are not disclosing their concerns directly, thus meaning that the true agenda may remain unfulfilled. Grice (1975) would consider this a flout, or even a violation, of the manner maxim (note that the distinction here between a flout and violation is that the flout may be considered to be accidental, whereas a violation would be done with intent to purposely make the utterance and content of the utterance ambiguous). This could be because the utterance (line 348-351) a) does not make it clear that the patient is referring to cancer, and b) as a result of this, makes it difficult for the medical student to explicitly address the patient's concerns; in the worst case scenario, the student may misinterpret what the patient intends. However, it can be seen from the student's response to this in lines 352-353 that they acknowledge the patient's concern, and then subsequently in lines 356-357 ask for more details about the issues. Once this information is obtained, they proceed to offer a sequence of reassurance (line 359-367), where they first state the probability that it would be unlikely to be anything more sinister (line 363-364), and then offer further support (line 366-367) for the patient to have more investigations should they feel the need. Although it is not made explicit that the student is referring to cancer here, the use of the term 'sinister' reflects the patient's concerns about this issue, and suggests to the

greatest possible extent that they have understood the simulated patient's underlying concerns. Hence it may be considered that this act was coded as empathetic due to the student addressing the patient's concerns without the patient having to use the word 'cancer' directly.

The following example also relates to this ambiguity when discussing cancer:

(30) [010]

124	Patient:	do you think they'd have looked to see if
125		it was (.) cancer or not (.) or
126	Student:	well with the sigmoidoscopy they would
127		have been able (.) to check your um (1.0)
128		the lower part of your colon
129	Patient:	right
130	Student:	and um (.) obviously that doesn't (0.5)
131		exclude (0.5) everywhere
132	Patient:	hmm-[no
133	Student:	[near your bowel
134	Patient:	so there's quite often blood on the (.)
135		toilet paper and stuff
→ 136	Student:	right okay (.) and can you describe what
137		the blood was like
138	Patient:	it was red
139	Student:	°°it was red (.) okay°° well um (.) often
140		they say that when the blood is more fresh
141		er red-dy colour (.) that's likely to be
142		something from around the area (.) like
143		haemorrhoids (.) or perhaps (.) if the
144		blood was darker (.) or mixed in with the
145		stool itself (.) that would indicate a
146		bleeding higher ↑up

Here, it is argued that the medical student is attempting to avoid a discussion about cancer directly by focusing the conversation on the physical symptoms, and as a

result, missing an opportunity to elicit the patient's concerns about cancer further. The patient mentions the concern about cancer on line 125, but the word is not used by the medical student at all in the following sequence, where they instead choose to focus on the medical procedures (line 126-128) and physical symptoms (line 136-137; 140-146). Despite this, the section of transcript marked with an arrow and focusing on physical symptoms was coded as being empathetic even though the concern was not explicitly discussed. This could have been because the act which was deemed to be empathetic involved the student trying to show they had understood the patient's concern about the cancer, even though they did not openly talk about it. The discussion of the physical symptoms and their likely interpretations offers a form of reassurance to the patient, and hence is likely to be why this was perceived to be an empathetic act.

In contrast, the following example shows the medical student realising that they were laying too much emphasis on physical symptoms, without addressing the psychological concerns of the patient, and thus brought up the idea that the symptoms could be cancer-related:

(31) [006]

192	Patient:	=so you're sure it isn't anything else
193		°°more serious°°
194	Student:	no no °no° that's why >so with-with the<
195		scope they will've (.) um >y'know< if they
196		didn't explain this to you at the time
197		(0.5) they look sort of right round the
198		back (.) because of course i mean you can
→ 199		imagine you perhaps might be concerned
200		that it could be <cancer> or something
201		like that
202	Patient:	yeah well my (.) my dad (.) had bleeding
203		from his back passage

The effect of not focussing on the procedure and symptoms, but rather explicitly referring to the concern that it might be cancer allowed the simulated patient the

opportunity to divulge their true agenda: that they were concerned that the symptoms were connected to a problem in the family history. Herein lies the issue of whether it is more beneficial for the medical student to explicitly bring up and discuss the concern about cancer with the patient (and potentially expose them to the negative connotations associated), or maintain an element of ambiguity and wait for the patient to explicitly mention 'cancer'. The medical student cannot be sure that the patient is referring to a concern about cancer without the simulated patient first disclosing this, and so for them to bring 'cancer' up in the consultation may seem startling for the patient. In this case however, it worked well and provided the medical student with necessary information.

One of the issues here seems to relate to the medical student attempting to understand the concerns that the patient is hinting at, and then verbalising these back to them. The problem is the way in which these concerns are elicited. There appeared to be a distinction in the data between the students enquiring about the simulated patient's surface concerns (the concerns which the simulated patient would openly and willingly divulge when asked), and their deeper, underlying concerns about the condition, for which they are not so eager to divulge. In the following example, the student asks at the start of the consultation very generally about the surface concerns of the simulated patient to get an overview of the patient's experiences with the illness:

(32) [004]

51	Patient:	=so today i'm hoping that um (.) we'll be
52		able to talk about the treatment really
53	Student:	okay (.) yes certainly we'll do that (.)
→ 54		um (0.5) could you just tell me what it is
55		that's mostly been concerning you about
56		the haemorrhoids what what problem they're
57		causing you

In contrast to this, the following are examples where the medical student attempted to understand the simulated patient's underlying concerns more thoroughly:

(33) [010]

87 Patient: [um (.) d'you (.) can you (.) i
88 mean (.) do you >know if it's< anything i
89 need to worry about or

→ 90 Student: is there something that you have in mind

91 Patient: well my (.) um my dad had bleeding from
92 his back passage and uh (.) it turned out
93 he had bowel cancer

(34) [012]

365 Patient: [can i just ask i mean is the
366 (.) could it be (0.5) something like a
367 sign of something worse

368 Student: um (.) i probably should have asked you
369 that before but um (.) it's usually a sign
370 of (.) the constipation more than anything
371 else (.) i-i-if it does change at all then
372 you do have to worry

373 Patient: right okay

→ 374 Student: is there anything in particular that you
375 were worried about

376 Patient: well just (.) worried that (.) my dad had
377 a bleeding from his (.) y'know backside
378 and (.) it turned out to be colon cancer

379

In these two cases, the patient initiates a sequence with a hint about their concerns that their symptoms may be connected to cancer (example 34, line 88-89 and example 35, line 366-367). This is followed by the medical student delving into the underlying concerns of the patient by asking about what the simulated patient is referring to specifically (example 34, line 90 and example 35, line 374), and as a result, discovering the patient's true underlying concern about the connection of their physical symptoms with their family history. This process supports findings from previous research (Suchman et al., 1997) where this form of interaction is referred to as a 'Potential empathetic opportunity continuer'. Hence when confronted by an

utterance which the medical student feels may be hinting at an underlying concern, this method of asking about specifics seems to help reveal the underlying concern without making assumptions about what the patient is referring to. The concerns of the patient may be classified as those which are more obvious on the surface, and those which are underlying, and in many cases, that the patient is reluctant to talk about directly.

Although all of the instances above were coded as empathetic, some of the examples provide more useful information than others (for example, example 33, and the use of Potential empathetic opportunity continuers in example 34 and example 35 give the most complete picture of how the patient is feeling). Even though empathy is perceived to be present in the other examples, it does not necessarily mean that the medical student has elicited the patient's feelings to the greatest possible extent. While these strategies may be perceived to be involved in empathetic expression and thus be beneficial to the patient on a therapeutic level, if they fail to provide details about the patient's concerns relating to bowel cancer and the connection to the family history, then it is the responsibility of the medical student to elicit these concerns further.

This section has highlighted the importance of addressing the patient's cues directly, and to not focus too heavily on their physical, rather than psychological, well-being when awkward topics arise.

8.1.6. Isolation

Patients may often feel isolated due to their inability to relate to anyone about the lived experience of the illness. The medical student's exploration of this was coded as an empathetic strategy in the data, and consisted of them discussing the commonality of the ailment, and then developing this further to incorporate facts and figures. In many cases, the medical students were keen to convey how common haemorrhoids were in the population; for example 'haemorrhoids are extremely common' (001, line 174); 'they're >they're< very common um in a lot of people' (004, line 165); 'they're very

common' (012, line 185). There were also variations on this, which had the same effect: 'it's completely natural' (012, line 304); '>it happens to a lot of people<' (009, line 144); 'most people that (.) that works on' (013, line 307). All of these utterances were coded as being empathetic by at least one participant, and this is likely because it allows the medical student demonstrate to the simulated patient that the illness they are experiencing has been experienced by others. The effect this had is to make the simulated patient feel less isolated with the illness, and also indicates to them that they have a better chance of treating the ailment successfully if other people have been though the same situation and recovered. The medical student discussing the commonality of the ailment is further backed up in a couple of cases through the use of facts and figures:

(35) [003]

344		Student:	y-y-yes yeah so (.) it is it is diagnosed
345			as haemorrhoids nothing more serious °>than
346			that<° which is [which is good news
347		Patient:	[yeah (.) yeah
→	348	Student:	um (.) you're in good company (.) fifty
	349		percent of the uk population will have
	350		haemorrhoids at some point in [their lives

(36) [011]

171		Student:	so um obviously then (.) if you're sitting
172			on them then that's going to be really
173			painful
174		Patient:	mm
→	175	Student:	okay (.) so um (0.5) they're very common
	176		(.) um half of the population huv have
	177		them at some point in their life [so

The use of statistics here takes away the subjectivism of the claims, and Grice would argue that this makes the consultation more felicitous with regard to the quality maxim (Grice, 1975: 78-79). The doctor could say 'it's very common, don't worry'

just to help the patient feel better, but the use of statistical evidence mitigates this potential for the doctor to put a positive spin on the outlook. From the patient's perspective, the use of statistics mitigates the chance that the medical student is flouting the quality maxim: they are more likely to be telling the truth about their condition as the statistical aspect provides an element of objectivity on the medical student's part. Effectively, it makes the medical students' statements more reliable and believable to the patient.

This section has presented some of the important factors involved in empathetic expression which stem from the consideration of the patient's feelings. The patient's attitude towards the illness and their desire for treatment has been examined, as well as a contemplation of the patient's emotional state. From the analysis, the following suggestions are made about what is deemed to be an empathetic expression with regard to the patient's feelings:

- Verbalise opinions on patient's thought processes.
- Express consideration for the patient's lived experience of the illness, and how their subjective experience may differ from another patient with the same disease.
- Use euphemistic language when discussing topics the patient may find embarrassing or distasteful if the patient's preference for this is clear.
- Attempt to elicit both the patient's surface and underlying concerns. They may not divulge sensitive information without further exploration.
- Refer to the patient's potential feeling of isolation, and give them examples with facts and figures that they can relate to.

8.2. PATIENT KNOWLEDGE

8.2.1. Current Knowledge

Patient knowledge was a key factor in the perceived expression of empathy. There were many examples coded in the data showing how the medical student would

check the starting point of the simulated patient, gaining information about what the simulated patient already knew about the illness:

(37) [004]

99	Student:	so if you could just start by telling me
→ 100		what ↑you know about haemorrhoids (.) what
101		↑your understanding of them is
102	Patient:	u-i don't really know very-v-very much at
103		all to be honest now i understand i mean
104		everyone i've spoken to n that i
105		understand now why people are so ( )
106		(.) i-i-i really don't know very much (.)
107		to be honest
108	Student:	so if it's okay ss-um i sort of tell you a
109		bit about them

(38) [006]

28	Student:	so um (.) if i could just >sort of< start
29		um (.) could you sort of tell me what's
→ 30		been going on so far and >sort of< what
31		you know all re↑↑ady
32	Patient:	um (0.5) yeah i mean (1.0) er basically i
33		went to the doctor (.) six months ago (.)
34		because i had some bleeding from my back
35		p-passage

(39) [008]

130	Student:	mmmk (.) well would you like to tell you a
→ 131		little bit about (0.5) um well what do you
132		already know about haemorrhoids sorry
133	Patient:	um they're some sort of blood vessel (.)
134		er they that's expanded
135	Student:	okay (.) would you like me to go on and
136		talk to you a little bit about what
137		haemorrhoids are [and (.) what may have
138		↑caused them

139 Patient: [yes (.) yes please yeah
140 (3.0) yeah

(40) [013]

→ 40 Student: and have they explained to you what
41 haemorrhoids actually mean

42 Patient: umm (.) well i (.) the consultants were
43 saying it's inflamed (.) blood vessels °or
44 something like that°

The effect of the medical student asking the simulated patient how much they know already is related to both the quantity and relevance maxims (Grice, 1975: 78-79). Checking the simulated patient's starting point acts as a prelude to these maxims; the medical student is ensuring that any subsequent information given to the simulated patient is relevant to the simulated patient's needs, and that they are not giving the simulated patient too much, or too little information. For example, if the simulated patient is playing the role of a patient whose occupation is a neuroscientist, it may be unnecessary for the medical student to begin giving basic information about the brain, as the simulated patient would likely already know this. However, if the simulated patient had never heard of a particular illness before, then a more detailed and basic starting point would have to be established. In the above examples, the difference in the patients' knowledge is shown by their responses to the medical student's question. In example 37, the patient states that they have little knowledge on the topic (line 106); in example 39 (line 133) it is clear that the patient already has some basic knowledge as to what haemorrhoids are, but not an extensive amount. Therefore, following from each of these questions, the student follows up by stating that they will give the patient more information on the topic. By asking the patient's starting point first, the student has made sure the information they proceed to discuss will be relevant to the patient's wants, and the right amount of information for them, hence Grice would argue that this type of act abides by the relevance and quantity maxims (Grice, 1975: 78-79), and is arguably where the empathetic content of the utterance comes from.

As well as clarifying the starting point of the simulated patient, the medical students also checked the simulated patient's current knowledge with regard to specific aspects of the illness. For example:

(41) [001]

75 Student: i'll go through it again (1.5) well um sss
76 haemorrhoids can be staged from um (.)
77 they're they're given stages >one two
78 three and four<

79 Patient: yeah

→ 80 Student: have you been explained stages

81 Patient: the um the doctor at the hospital said
82 mine were a gr↑ade two

(42) [011]

145 Student: um (.) okay so (.) um haemorrhoids what
146 they are is um (1.0) around (.) around the
147 back passage (.) um there's lot of (.) um
→ 148 (.) veins now do you know what veins are

149 Patient: yeah yeah

(43) [012]

→ 139 Student: um (.) you ss understand it's something
140 about veins is that right

141 Patient: yeah well blood vessels i think yeah

142 Student: well that's absolutely right

Like the prior examples, these all involve the medical student trying to establish what the patient already knows, and what they want to know in addition, thus creating empathy through attempting to make the consultation personalised for the patient by being relevant and not giving too much/little information (again Grice would argue that this function as abiding by the relevance and quantity maxims (Grice, 1975: 78-79)). However, it could be argued that these examples are all

potential face threatening acts, as they presuppose that the patient does not know about something which the medical student does, hence threatening the patient's positive face (their desire to be unimpeded by others) (Brown and Levinson, 1987). An example of how this threat to face is mitigated is shown below:

(44) [003]

316 Student: but um the more invasive surgery something
→ 317 called a haemorrhoidectomy which is a big
318 word but

319 Patient: mmm

320 Student: that's urrm ef↑↑fective (.) but it's it it
321 can be associated with more ↓pain
322 afterward after the

Here, the medical student mitigated the threat to the simulated patient's face by interjecting in their own utterance on line 317 to show they understood that the patient may not have been familiar with what a haemorrhoidectomy was. While the content of this sentence could have been interpreted as patronising, the tone of voice used by the medical student when saying 'which is a big word' had a jovial quality to it, almost mocking the word itself, and expressed to the simulated patient that although the word was complex, its meaning was much more simple.

Relating to the simulated patient's current knowledge, their negative face (Brown and Levinson, 1987) was also saved through the medical students' avoidance of jargon. Again, jargon relates to negative face because it is undesirable for a patient to lose face in a consultation as a result of not understanding the medical student's specific language. Through the medical students' use of simple and clear language, this loss of face was mitigated, as the patient was able to clearly and easily follow the content of the consultation, without having to ask (and lose face) what certain terms meant. Evidently, a degree of cognitive empathy was required for this, as the medical student had to find the appropriate level at which to pitch their explanation to the simulated patient. Moreover, if they had simplified the language too greatly, it

may have had the opposite effect, sounding condescending or patronising to the patient. For example:

(45) [003]

```
114   Student:  um so the swelling is because there's a er
115             (.) um there're a sort of small blood
116             vessels (.) that can become eng↑orged with
117             blood and (0.5) that's what causes the
118             swelling
```

(46) [004]

```
114   Student:  um (1.0) around um your anus which is the
115             opening of your bowel which is part of
116             your rectum where the um faeces is stored
→ 117           there's lots of (.) um blood vessels (0.5)
118             um and these become >sort of< enlarged and
119             um get inf↑lamed and that's what (.) the
120             haemorrhoid is it's basically it's the
121             bulging of this blood vessel that's
122             surrounding tissue
```

The use of the word 'engorged' rather than 'enlarged' made it more difficult to understand for the simulated patient. The simulated patient commented during the feedback that they found the explanation with 'engorged' more difficult to follow, and this was reflected in her response to each explanation. Where the medical student used 'engorged', and asked if their explanation had been understood, the simulated patient replied with ambiguity: 'well it's interesting', whereas when the term 'enlarged' was used, the response was to confirm the understanding, with 'right'. In rare cases, the medical student would adopt the lexical field which had been used by the simulated patient. In the following example, the simulated patient uses the term 'piles':

(47) [009]

```
31   Student: °°kay°° fantastic (.) so (.) what brought
32            you in to see your GP today
```

33 Patient: umm i've actually had (.) quite a problem
34 with um (0.5) um IBS for (.) for (.) >sort
35 of< twenty years or so (.) and um (.) i
36 think perhaps that's led to (0.5) um (0.5)
37 piles that i've got

38 Student: kay

Later in the same simulated consultation, rather than using the term 'haemorrhoids' to refer to the ailment, the medical student adopted the simulated patient's term 'piles' in the description on line 82. Hence they were using the simulated patient's lexis, rather than their own medical lexis to build rapport and create commonality with the simulated patient through an indirect expression of understanding of the simulated patient's perspective. Grice would argue that this shows checking the simulated patient's starting point can help the medical student to abide by the relevance and quantity maxims (Grice, 1975: 78-79). However, in asking the simulated patient about their current knowledge there is a threat to face, but this can be mitigated through highlighting the incongruity of perceived complexities in the language, and avoiding jargonistic terminology.

8.2.2. Desire for Knowledge

In addition to checking the simulated patient's current knowledge, the medical students checking the simulated patient's desire for certain types of knowledge about the disease was also coded as an empathetic act. This included the medical student asking broadly about what information the simulated patient wanted in the consultation:

(48) [002]

39 Patient: umm (.) and then (.) he referred me to see
40 someone else (.) um and we saw a
41 consultant there (.) and he did (.)
42 different (0.5) tests (.) um (.) and he
43 (.) basically said that he thought it was
44 (1.5) °°haemorrhoids°° um and um and i'm

45 back today to have a chat about what's the
46 next step really

→ 47 Student: okay (1.5) right (.) cos er what i'd like
48 to do in our discussion if it's alright
49 with you (.) is um (.) just start from the
50 beginning really (.) um check that you're
51 (.) sorry are you alr↑ight there

52 Patient: thhhh yeah

(49) [004]

111 Student: so if it's okay ss-um i sort of tell you a
112 bit about them

113 Patient: yeah

→ 114 Student: um (.) and then what sort of information
115 do you want to get from me today

Also, it involved going through specifics about the disease:

(50) [008]

130 Student: mmmk (.) well would you like to tell you a
→ 131 little bit about (0.5) um well what do you
132 already know about haemorrhoids sorry

133 Patient: um they're some sort of blood vessel (.)
134 er they that's expanded

(51) [010]

50 Student: yeah that's (.) that's correct (.) um
→ 51 would you like to know a bit about what
52 haemorrhoids=

53 Patient: =yeah i think it would be useful yeah

The medical student checking the simulated patient's desire for knowledge functioned as a prelude to ensuring the right amount of information would be given

to the patient (Grice would consider this as a method of abiding by the quantity maxim (Grice, 1975: 78-79)). It was a method for gauging how much information would need to be given to the patient (e.g., starting from the beginning, or building upon what they were already familiar with). In the same way that checking the simulated patient's starting point in the previous section impacted upon the information given, so too did the simulated patient's request for certain knowledge. For instance, in practice, a patient may be happy to be prescribed a drug they know nothing about and trust that the doctor knows best. However, another patient may wish to know more about the drug if they feel uneasy about it, do not trust the doctor's judgement, or are just genuinely interested in the treatment regimen. This said however, the doctor must be aware of the patient's limitations regarding the giving of information; for example, one of the medical students acknowledged this by claiming 'i know i explained a lot to you there' (006, line 272). Thus it can be seen that by checking the simulated patient's desire for knowledge, the medical student can better tailor the consultation to the simulated patient's wants and needs, saving both parties valuable time in the process.

8.2.3. Treatment Options

Following on from above, the medical students' discussion of treatment options was another communicative aspect coded as being an empathetic act. The medical students checked the simulated patient's desire to know about the various treatment options:

(52) [010]

87 Patient: [um (.) d'you (.) can you (.) i
88 mean (.) do you >know if it's< anything i
89 need to worry about or

→ 90 Student: is there something that you have in mind

91 Patient: well my (.) um my dad had bleeding from
92 his back passage and uh (.) it turned out
93 he had bowel cancer

(53) [015]

184 Patient: and he said they were (0.5) um (.) a grade
185 two

186 Student: okay (.) yeah

187 Patient: i don't really know what that means

→ 188 Student: okay (.) sure (.) okay would you like me
189 to talk about (.) the different gradings
190 of haemorrhoids

191 Patient: well if (.) yeah i'd like to know what it
192 means

(54) [013]

→ 147 Student: okay (1.5) well um (.) if it's alright
148 with you i-i'll discuss some of the
149 surgical things and-and we'll talk about
150 (.) um (.) obviously some of them aren't
151 perfect and we're going to have a hundred
152 percent

153 Patient: right

They also discussed the simulated patient's prior knowledge of treatment options with them:

(55) [008]

226 Patient: four okay then so i'm about (.) >sort of<
227 obviously about halfway to (.) i mean what
228 about treatment then can you give me any
229 advice about that

→ 230 Student: yeah (.) um (.) do y-have you heard about
231 any treatments

232 Patient: um i think i knew somebody that had (.)
233 bands put on and

(56) [014]

139	Student:	okay (1.0) alright um (0.5) can you tell
→ 140		me (.) what do you know about the
141		treatments or any treatments you'd prefer
142		[or
143	Patient:	[well i (.) i don't know anything about
144		treatments at all
145	Student:	[okay

(57) [001]

55	Patient:	so um i was hoping that we could you know
56		(.) cover that
→ 57	Student:	certainly (0.5) and what do you understand
58		(.) what the options are at the mo↓ment
59		°for you°
60	Patient:	um (.) i don't i don't really know

As with checking the patient's knowledge and desire for knowledge about the disease, the effect this had was to help the medical student save time in the consultation, as well as open up the floor up for the simulated patient to pursue their agenda. Thus, Grice would consider this a method for the student to abide by the quantity maxim (Grice, 1975: 78-79). Specifically with regard to treatment options, the medical students also checked what the simulated patient had already tried (002-137; 005-72), and also ensured that the simulated patient realised the limitations of the specific treatment regimen (014-78):

(58) [002]

→ 137	Student:	um what have you heard so far about what
138		you can do
139	Patient:	uh (.) i don't (.) i don't know anything
140		as yet (.) um (.) i would im↑a↓gine (.)
141		that (0.5) there are several things that
142		we can look at but i'm willing to try
143		any↓thing at the moment to be ↓honest

(59) [005]

69 Patient: well yeah i mean if i could just get it
70 sorted out once and for all that would be
71 (.) such a relief you know i'm just

→ 72 Student: mmm (.) have you tried any things though
73 to help the haemorrhoids

74 Patient: well um (.) when i get the IBS badly i (.)
75 um (1.0) take fibre gel

(60) [014]

69 Student: mmk (.) um (.) there's things like
70 drinking lots of water and what that does
71 (.) that helps prevent having really hard
72 poos

73 Patient: ri[ght (.) right

74 Student: [plenty of water and staying hydrated

75 Patient: right

76 Student: so these are simple things that you can do
77 to try and prevent them (.) err getting
→ 78 any worse it won't cure what you've
79 already got but it'll stop (.) future ones
80 occurring

Therefore, it can be seen that it is considered an empathetic act to not just ask about the simulated patient's knowledge and desire for knowledge with regard to the disease itself, but also the treatment regimen as well.

8.2.4. Praise of Patient Knowledge

In a small number of cases, general praise of the simulated patient's knowledge was coded as empathetic:

(61) [001]

224 Patient: um i don’t eat meat (.) but i do eat fish
225 and plenty of (0.5) plenty of fruit and
226 vegetables actual↑ly

227 yea= (.) yea

→ 228 Student: =that’s very good (.) and (.) your water
229 intake is that good

(62) [008]

→ 145 Student: you’re you’re correct in saying that
146 they’re vessels

(63) [010]

→ 54 Student: okay (.) well you’re right it is to do
55 with blood vessels and it’s where they um
56 (.) are sort of slightly larger than
57 perhaps they should be

(64) [012]

144 Student: um (.) you ss understand it’s something
145 about veins is that right

146 Patient: yeah well blood vessels i think yeah

→ 147 Student: well that’s absolutely right

All of these instances were *only* coded by the simulated patients as an empathetic strategy, and could arguably be considered a deviant case. Moreover, it was not just one of the simulated patients who coded these, but there were examples from both. It could be argued that it is a strategy for enhancing the positive face (Brown and Levinson, 1987) of the patient, through simulating their wants and needs, but appears to be more akin to general politeness strategies than an empathetic act. Thus there is some discrepancy here over how empathy is realised in interaction, and this is

especially important with regard to the empathetic content assessment process in the OSCEs, thus further research would be beneficial in this area.

To summarise the above sections, the following were perceived to be involved in expression of empathy within the consultations:

- Checking the patient's starting point with regard to both the disease, and their knowledge of the treatment options.
- Checking the patient's desire for knowledge with regard to both the disease and treatment options.
- Avoiding the use of jargonistic terms, as these may confuse the patient's understanding of any information given to them.
- Praising the patient's knowledge is deemed an empathetic strategy, although further work needs to be conducted into exactly how and why this is the case.

8.3. COMFORT

Considering and enquiring about the simulated patient's comfort levels was a regularly occurring strategy used by the medical student which was deemed to be involved in empathetic expression. Both role-players made it very obvious from the start of every consultation that they were uncomfortable sitting down, wriggling and squirming and on occasion pulling a face showing discomfort. This was done automatically on the part of both role-players without any input from the researcher, and in many cases led to the student enquiring about the simulated patient's comfort levels. Two methods were identified in this as being empathetic, which consisted of the medical student asking about the simulated patient's immediate comfort and the medical student asking about the simulated patient's continuing comfort.

8.3.1. Immediate Comfort

By far, the most commonly used strategy when enquiring about the simulated patient's comfort was for the medical student to focus on the simulated patient's immediate comfort: how comfortable they were at that point in time. This is likely

due to the blatancy of the simulated patient's discomfort in this scenario; a patient with haemorrhoids will suffer more when sitting for prolonged periods, and this was conveyed well by the role-players. The medical student solicited information pertaining to the simulated patient's immediate discomfort in two ways: through the use of declaratives and interrogatives. Interrogatives were commonly used at the beginning of the consultation and aided in building rapport between the medical student and simulated patient. They consisted of a very simple question directly asking the simulated patient about their level of comfort with regard to them sitting: 'are you sitting comfortably' (002, line 23); 'are you sitting there comfortably' (007, line 14); 'uuu you sitting comfortab↑ly' (008, line 10); 'are you sitting comfortably' (012, line 30).

Grice might argue that in the above cases, the medical student was flouting the quality maxim (Grice, 1975: 78-79). They were aware at the start of the consultation that they would be dealing with a simulated patient who had haemorrhoids, and the chances were that the haemorrhoids would be causing the patient some degree of pain when they were sitting. Hence the medical student was aware that the question being asked is almost arbitrary or untrue, as they should already have been able to deduce that the patient was uncomfortable. Despite this, these utterances were still coded as being empathetic. It is likely that the process of asking about the patient's comfort acts as a schematic mechanism where it is desirable for someone to take an interest in you (and your comfort). So, while the medical student can observe and deduce that the simulated patient is <u>not</u> sitting comfortably, by asking, they are showing that they have recognised the simulated patient's discomfort, and this has the effect of letting the simulated patient know that their problems are being taken seriously. To build upon this, it may theoretically enhance the empathetic content were the medical student to qualify the question afterwards with an utterance such as 'I mean obviously as comfortable as you can be', however, this was not apparent in the data.

In addition to the medical student asking about the simulated patient's comfort when seated, there were also instances coded that related to the general comfort of the

simulated patient during the consultation, when they gave a non-verbal cue that they were in discomfort. For instance: 'sorry are you alr↑ight there' (002, line 51); 'are you getting a bit uncomfor[table there' (007, line 238); 'are you okay there' (011, line 274). Unlike the previous examples, these occurred in response to observing a specific case of the simulated patient's pain during the consultation. These were used in response to the simulated patient demonstrating their pain through obvious non-verbal means, most commonly wiggling and squirming at certain points in the consultation. One medical student went one step further in relation to this, and asked the simulated patient whether they wanted to pause the consultation:

(65) [003]

187	Student:	um in terms of (.) um dealing with the
→ 188		actual ↓problem (.) are you okay there do
189		you want me to stop
190	Patient:	no you're okay

Here, the simulated patient's pain is being acknowledged by the medical student, and through this action, it has the therapeutic effect of letting the simulated patient know that they are being taken seriously. Also, by asking if the simulated patient wishes to stop, the medical student is opening up the floor to the simulated patient to alter the agenda, thus giving them an element of power, and making the consultation more patient-centred.

As well as interrogative structures, declaratives are also used in reference to the simulated patient's comfort:

(66) [001]

187	Patient:	um (0.5) and is there any chance ↑of (.)
188		of them going away
189	Student:	sure (.) okay (.) well they're reasonable
190		questions to ask
191	Patient:	mm

→ 192 Student: you seem to be in a bit of discomfort now

193 Patient: yeah

(67) [002]

145 Patient: because the last six months they've been
146 (.) excruciating

→ 147 Student: ss i can see you're quite uncomfortable at
148 the moment

149 Patient: yeap

In both of these examples, the medical student is giving his or her opinion on the simulated patient's level of pain, having the same cognitive affect on the simulated patient as before, but giving the simulated patient less opportunity to respond and expand on their problems. Perhaps the most effective and sincere method for enquiring about the simulated patient's comfort was for the medical student to follow up the first time of asking about comfort with another in the same interactional sequence:

(68) [014]

302 Student: and it's (.) just have some local
303 anaesthetic (.) i can see you're really
304 uncomfortable there

305 Patient: i am

→ 306 Student: are you alright

307 Patient: i am uncomfortable

→ 308 Student: do you want to have a [break or

309 Patient: [i-i'll just perch

By using this combination, the medical student is making their interest in the simulated patient's problems more felicitous. The fact that they follow up by giving the patient the opportunity to take a break shows that they are actively trying to assist

the simulated patient, and not simply saying what they are expected to without meaning it.

8.3.2. Continuing Comfort

Continuing comfort refers to the simulated patient's day-to-day experiences, and not simply the pain that they may feel at a given point in the consultation. As with immediate comfort, declaratives were also coded as empathetic, and used to comment about the simulated patient's continuing comfort: 'you're obviously in pain' (001, line 301); 'you sound like you're in quite a lot of pain' (008, line 307); 'you don't really want to be sitting down when you're uncomfortable down there' (005, line 304). However, in contrast to asking about immediate comfort, interrogatives used to enquire about continuing comfort were not coded as empathetic. While there were some more general questions which arguably could serve the same function, such as 'how is it affecting your lifestyle', the majority of these adopted a declarative structure. It could have been useful for the medical student to ask 'how is the pain affecting you day-to-day'; however, generic questions about the effect the illness is having on the patient are probably a better method for this, as it leaves room for the patient to elaborate on other factors (such as embarrassment or concerns), rather than focussing on the pain.

Therefore, the medical student asking about levels of comfort was deemed to be associated with empathetic expression, and was achieved in the following ways:

- A medical student must consider both the immediate and continuing comfort of the patient.
- Immediate comfort may be explored through a combination of declaratives and interrogatives.
- Continuing comfort is more commonly explored through declaratives, but should be covered by more generic questions about lifestyle in other parts of the consultation.

- A medical student may ask if a patient wishes to pause or stop the consultation when they notice obvious discomfort on the patient's part.

8.4. LIFESTYLE

8.4.1. General

The consideration of the simulated patient's lifestyle was coded as a method of empathetic expression. The impact of the disease upon the simulated patient's general lifestyle was alluded to in the previous section on continuing comfort, and here this is expanded to explore the broader aspects of considering the patient's overall lifestyle, rather than focussing on how the pain affects the patient. The lexical item 'impact' was associated with expressing empathy in relation to the simulated patient's lifestyle in a number of cases:

(69) [003]

265 Patient: especially with work and stuff and so

→ 266 Student: how has it impacted on your

267 Patient: well um my husband and i have our own
268 business we're book binders and printers
269 (.) we work from home but it does mean
270 that (.) i'm very sedentary actually at
271 work

(70) [004]

67 Student: okay (0.5) well to be honest it is causing
68 you a lot of [discomfort

69 Patient: [yeah it is yeah

→ 70 Student: and i imagine that's having quite an
71 impact on your life

72 Patient: well it does because my husband and i um
73 (.) we're self employed we (.) we run a
74 book binding (.) um company

(71) [004]

374 Patient: i think that probably it (.) even with
375 surgery you know i'm a bit (0.5) about
376 surgery but i think if i thought they were
377 going to get rid of them (.) then i (.)
378 i'd be more inclined to do that

→ 379 Student: it does sound like a good idea because
380 they're obviously impacting on your life

381 Patient: yeah

In addition to this, formulations including the word 'affect', and derivations thereof, were also coded as an empathetic act surrounding the simulated patient's lifestyle:

(72) [004]

46 Patient: um (.) they said i've got grade two (.)
47 haemorrhoids (1.0) um (.) er (.) really i
48 (.) must get something done about that (.)
49 y'know i don't know what °to do° (1.0) i
50 just can't go on like this really

→ 51 Student: it must be really >affecting you< as well

52 Patient: i-it does you know i have to sit down a
53 lot [um for my work

(73) [011]

76 Student: [okay (.) °okay° (.) um well that's
77 brilliant i (.) seem to feel like i've got
78 a good idea about what's happening (.) can
79 you just tell me a bit about (.) how
→ 80 they're >sort of< affecting you day to day

81 Patient: um (0.5) well they're really (.)
82 exc↑ruciating (.) sometimes (.) i-it you
83 know in the in the espesh (.) in the last
84 six months they've got worse (0.5) but in
85 the last few weeks they (.) i think
86 they've really got (.) much worse and um

87 (.) i'm self-employed my husband and i've
88 got um (.) book binding company

(74) [015]

254 Patient: i can't believe that it could be any worse
255 than it is cos it (.) to be honest in the
256 last six months it's just become
257 absolutely excruciating

258 Student: °must be hard° (.) um has um how has it
→ 259 been affecting you you seem in quite a bit
260 of pain at the moment as well

261 Patient: well it is really difficult an i mean uh
262 (.) the problem is (.) i-i-i spend an
263 awful lot of my time (.) sitting [at work

The use of these two words (and derivations thereof) appears to act as a link between the medical student's agenda and the simulated patient's agenda. It is a method for the medical student to link the medical problem (the disease) to the simulated patient's experience (the illness). In the process, Grice would argue that this allows for the medical student to abide by the relevance maxim (Grice, 1975: 78-79) by ensuring that their own medical agenda is relevant to the agenda of the simulated patient.

8.4.2. Occupation

As well as general questions about the impact of the disease on the simulated patient's lifestyle, there were specific instances coded which related to the disease's impact on the simulated patient's occupation:

(75) [001]

95 Patient: =it's been excruciating the last six
96 months

97 Student: the last six months

98 Patient: mmm

→ 99 Student: okay (0.5) and um (0.5) how's that
100 affected your ˚life˚ >are you working at
101 the moment<

102 Patient: well um i'm self employed

(76) [004]

84 Patient: i mean it's (.) y'know (.) sometimes i
85 stand up cos it's (.) it's so awf (.)
86 £it's so awful£ and um it would be great
87 if i could get back to normal

→ 88 Student: of course so it's having quite an impact
89 on your life interfering with ↑work and

90 Patient: definitely yeah

(77) [005]

166 Student: uh together with how (0.5) obviously it's
→ 167 affecting your life (.) and your (.) your
168 work as well (1.0) [maybe

169 Patient: [i-i'm quite (.) yeah
170 yeah yeah

171 _____

172 |

173 (⌀) (1.0)

174 |

→ 175 Student: _____ are you working nor↑mal hours have
176 you found that you have to (.) er work
177 less now

178 Patient: uh-t (.) if the work's there you just have
179 to do it y'know i (.) i'm quite fit i like
180 walking around a lot as well it's not like
181 i just sit all day (.) but um (1.0) yeah
182 (1.5) it's quite i'm quite concerned about
183 it the fact that it's carrying on y'know

Again, in both these cases, the terms ‘impact’ and ‘lifestyle’ are present, thus showing the link between agendas and what Grice would consider an abidance by the relevance maxim (Grice, 1975: 78-79). There were also more specific questions which related to the intricacies of what happened when the simulated patient was at work:

(78) [008]

59 Patient: well i mean i’m really just hoping (0.5)
60 that you know you can advise me on um (.)
61 the best way forward >i mean i’m-i’m<
62 getting so desperate now i really would go
63 for quite drastic treatment

64 Student: °okay i understand° it must be (.) °a bit°
→ 65 difficult for you especially as you say
66 you sit down a lot at work

67 Patient: well yeah i’m using a cushion to sit on
68 now i mean y’know (.) um (.) it is my own
69 business but there doesn’t seem to be a
70 way round it really i-i do have to sit
71 down a lot when i’m working

In the specific examples, the medical student appears to be taking a genuine interest in how the disease is affecting the simulated patient’s daily life. They are simulating what impact the disease is having on the micro aspects of the simulated patient’s lifestyle, such as the hours they work, and body position during work. This genuine interest in the simulated patient is further demonstrated in the following sequence:

(79) [008]

67 Patient: well yeah i’m using a cushion to sit on
68 now i mean y’know (.) um (.) it is my own
69 business but there doesn’t seem to be a
70 way round it really i-i do have to sit
71 down a lot when i’m working

→ 72 Student: what do you do↑

73 Patient: i-i'm a book binder and [printer

74 Student: [oh okay (.) uh
75 interesting

76 Patient: yeah

77 Student: do you en↑joy it

Here, the medical student does not simply ask about the simulated patient's occupation, but follows up the question with another question about the simulated patient's enjoyment of the job on line 77, thus indicating a more authentic interest in what the simulated patient has to say. Finding out about the simulated patient's occupation plays a role in the expression of empathy, as well as the decision of a treatment regimen, and this is highlighted with the coding of the following extracts:

(80) [006]

67 Student: so those are the five main treatments
68 (0.5) k if you're happy with those (.)
69 ummm just to quickly >sort of< look at the
70 pros and cons °i mean° all of them (.)
71 sometimes with the-the banding and the
72 >sort of< infrared you may have to go back
→ 73 for more than one treatment (0.5) i don't
74 know if that would be an issue wisss work
75 °n things°

76 Patient: well i'm self-employed but y'know if we're
77 busy obviously it's (.) hhfff quite
78 inconvenient (.) but then it's (.) very
79 uncomfortable at the moment for me to uh
80 y'know i'm sitting on a cushion basically
81 to get my work done

(81) [006]

500 Student: really severe ones (.) because the thing
501 with surgery is (.) it's quite (.) y'know
502 (.) sort of (.) it's not ( ) enough to
503 go down the route of general anaesthesia
504 and you're likely to need a week or two

→ 505 off work (.) particularly for yourself
506 being self-employed

507 Patient: yeah yeah

508 Student: that's not really something that you'd
509 probably want to consider anyway

(82) [011]

→ 500 Student: you won't have to take any time off work
501 or anything (.) which might be [an issue
502 with yourself

503 Patient: [mmm

In these examples, the period of convalescence is discussed in relation to the simulated patient taking time off work. Although not relevant for all patients, the vast majority will have to work to make a living for themselves; hence taking time off work due to an illness may have serious consequences on their lifestyle. The medical student demonstrates this understanding above by raising the issue, and reassuring the simulated patient about missing work.

It has been shown that asking about the simulated patient's occupation was deemed to be involved in the expression of empathy. However, while asking about the simulated patient's occupation and considering how the disease may affect their lifestyle helps to build rapport between the parties, enquiring about the simulated patient's job does have the potential thereafter to impede their negative face (Brown and Levinson, 1987), as the patient's desire to be unimpeded by others is threatened by the potential intrusion on their privacy. Although it did not occur in the dataset collected for this research due to the scenario used, it must be considered that if the patient has just lost their job, or has been unemployed for a long period of time, then asking about their occupation at the start of the consultation may hinder rapport. For instance, asking 'what do you do' at the start of the consultation presupposes that the patient is currently in employment; for them to say they are unemployed may threaten their positive face (Brown and Levinson, 1987). Moreover, if their feelings about being unemployed are particularly tender, then they may begin to explain to

the medical student how they have just lost their job and all the problems this has led to, again damaging rapport. If asking about the patient's occupation at the start of the consultation, then perhaps a more proficient way to do this would be to use a closed question, such as 'do you work'? This does not presuppose that the patient is in employment, and the patient is inclined to answer 'yes', or 'no', thus giving the medical student/doctor the information they require, while at the same time not damaging rapport between the interlocutors.

8.4.3. Personal

The final aspect relating to expressing empathy with regard to the simulated patient's lifestyle was enquiring about their personal life. Surprisingly, only one instance of this was coded in the data:

(83) [010]

→ 500 Student: um do you have any children

501 Patient: yeah we've got a daughter (.) she's
502 fifteen

503 Student: okay (.) and is she (.) a teenager or hhh.

504 Patient: she is yeah (.) fifteen yeah

Moreover, even though the simulated patient's family life was asked about here, it appeared that the medical student did not listen closely to the simulated patient's answer, as their follow-up question had already been answered by the simulated patient. It is curious why there was not more interaction about the simulated patient's personal life. It could be argued that this was generically covered through the medical student asking 'how is it affecting you'; however, there was still little mention of the simulated patient's hobbies, background and family. This could be due to the fact that the consultations were simulated, rather than authentic. Also, it could be because the medical student did not want to appear rude by prying into the personal life of the simulated patient, but further research may make the reasons for this clearer.

In conclusion, the following were deemed to be involved in the expression of empathy with regard to the patient's lifestyle:

- Linking the disease to the patient's lifestyle.
- Considering the impact of the disease on the patient's occupation.
- Considering the impact of the disease on the patient's personal life.

This chapter has discussed how the medical student used various interactional techniques to explore the patient's feelings towards having haemorrhoids, their knowledge about haemorrhoids; how the haemorrhoids affected their levels of comfort and the impact they had on the patient's lifestyle. The next chapter builds on this, but discusses how the medical student tailored their consultation to encourage moments of empathetic expression, rather than relying on the patient to initiate these instances.

CHAPTER NINE: INITIATING EMPATHETIC OPPORTUNITIES

9.0. INTRODUCTION

Suchman et al. (1997) originally defined an empathetic opportunity as a moment in which 'a patient directly expressed an emotion and created an opportunity for an *empathetic response,* in which the physician explicitly acknowledged that emotion'. This definition is used as a basis here, but also incorporates the broader aspect of empathy: an understanding of patient's *thoughts* as well as feelings. This is congruent with the latest research in the area, particularly the area of social neuroscience (Batson, 2009: 4-7). Hence, the use of term 'initiating empathetic opportunities' here is partly related to Suchman et al's (1997) definition, but also incorporates the necessity of a physician to understand the patient's thought processes, and increase the likelihood of these topics arising throughout the consultation.

In addition to the findings from the previous chapter, the way in which the medical student would initiate empathetic opportunities was a key finding drawn from the data. Whereas previous research has primarily been concerned with responses to patient initiated empathetic opportunities (Suchman et al., 1997, Morse et al., 2008), the coding indicated that empathetic opportunities were also initiated by the medical student. The following sections discuss the various communicative strategies coded as being empathetic, which involved the medical student initiating windows of opportunity (Branch and Malik, 1993) for the development and expression of empathy. Six main categories emerged from the data, and these involved rapport building, agenda setting, checking understanding, information retention and attachment of condition, reassurance strategies and professional perspectives.

9.1. RAPPORT BUILDING

Previous research has discussed the role of empathy in establishing rapport in the consultation, with rapport itself being described as 'a therapeutic alliance based on trust and cooperation, and established through a shared understanding of the patient's perspective' (Norfolk et al., 2007: 41). Deborah Cameron claims that 'creating rapport and showing empathy is about adding the human touch [in interaction]' (Cameron, 2000: 444), suggesting its link to empathy. Various factors which may be deemed to contribute to the construct of rapport were coded as being empathetic in the data, and rapport was also a central and recurring theme within the focus group. The categories derived from the coding conducted in this study which related to rapport have been loosely divided between the affect on positive and negative face (Brown and Levinson, 1987). The strategies coined from the member coding which involved the enhancement or protection of positive face included offering, praising, interest taking and agreeing, whereas the strategies coded in relation to negative face may be described as suggesting, apologising and positive proclamations, although it should be noted that these sub-categories have been developed to aid with the analysis and explanation of why certain techniques were deemed empathetic; the sub-categories are by no means fixed, and indeed there is overlap between other categories in the model. Each of the sub-categories is explored in more detail below in relation to the aspects of the simulated consultations which were coded as being empathetic.

9.1.1. Offering

Offering the patient something material was a strategy used for building rapport. It occurred when used in response to the simulated patient being in discomfort in the following examples:

(84) [002]

47 Student: okay (1.5) right (.) cos er what i'd like
48 to do in our discussion if it's alright
49 with you (.) is um (.) just start from the

beginning really (.) um check that you're
(.) sorry are you alr↑ight there

Patient: thhhh yeah

→ Student: can i get you any↑thing

Patient: no (.) no i'm alright (.) thank you

(85) [007]

Student: yeah (.) um (.) which is why (.) are you
getting a bit uncomfor[table there

Patient: [it'sss alright i'll
just (.) change position

→ Student: is there something i can [(0.5) get for
you

Patient: [no hhh. n-n-no
it's a ˚bit embarrassing but˚

Student: no yeah i can understand

Patient: ˚˚˚yeah˚˚˚

In both the above examples, the sections coded as empathetic are preceded by an indication that the patient may be in discomfort as a result of their ailment. The medical student asks if the patient is alright, and in both cases, the simulated patient responds by saying that they are okay. This then prompts the student to make an offer to get the patient something to alleviate the pain. The effect this had was to enhance the simulated patient's positive face (their desire that their actions be desirable to at least some others (Brown and Levinson, 1987)), as it demonstrated that the medical student was making a conscious effort to accommodate them and understand their thought process with an overt expression of empathy. Simply put, it demonstrated that the medical student had an interest in the patient's predicament. Juxtaposed with this, it could be interpreted that the medical student's own agenda was being impeded as a result, hence potentially threatening their negative face, as they were offering their time and energy to make the patient happier. In addition to making these offers to the simulated patient, future assistance was also offered. An

example of this was when the medical student offered to take time out of their day, should the simulated patient require further reassurance (example 86, line 238) and when the medical student provided an emotional offering to the simulated patient (example 87, line 33):

(86) [009]

237 Student: and also you've got (.) the practice phone
→ 238 number (.) you can always give me a ring
239 (.) or come in and have a chat with me

240 Patient: okay (.) thank you

(87) [011]

30 Student: and everything we talk about is
31 confidential=

32 Patient: =okay

→ 33 Student: so um (1.0) please feel free to be open

34 Patient: okay

Thus it can be seen that rapport is strengthened by offering the simulated patient both material items and emotional assistance, and hence contributes to what is deemed to be the expression of empathy in the consultation.

9.1.2. Praising

Another strategy used by the medical student to enhance the positive face (their desire to be accepted by others (Brown and Levinson, 1987)) of the simulated patient was for them to praise the simulated patient's actions to date:

(88) [002]

220 Student: if you increase the vegetables and (.) um
221 wholemeal (.) content=

222 Patient: =that's pretty good f-f-for me actually
223 (.) uh uh we don't eat meat >we eat fish<
224 but we do eat loads of (.) veg [and stuff

225 Student: [right (.)
→ 226 okay so pretty sure you're doing that one
227 al[ready

In this case, the praise is desirable for the simulated patient as it has the effect of absolving them of any blame for the continuation or progression of the disease. The simulated patient is being accepted by the medical student, and essentially being told that the disease is not their fault. This parallels the validation aspect of RAV in the Calgary/Cambridge model, and also relates to Talcott Parson's sick role (Parsons, 1951), namely that the sick person is not responsible for their condition. In addition to praising the simulated patient for their actions, one example which was coded as empathetic in the data consisted of the medical student praising the patient for *being* the patient:

(89) [009]

373 Patient: um (.) i can't think of any (.) anymore
374 really i mean obviously (1.0) th (.) there
375 are more extreme things they can do but
376 (.) mine aren't really that bad are they
377 in terms of some people's i suppose if
378 they go back in again

→ 379 Student: well (.) the thing is (.) we're meant to
380 be the experts here in (.) the actual
381 disease but you're the expert in who you
382 are (0.5) as a person (.) so really the
383 scale of one to four isn't really that
384 important (.) if it's causing you a
385 problem

386 Patient: yea[h

Here, the medical student is attempting to convey that although they can *try* to understand the lived experience of the patient, they will never be able to fully grasp

the condition in the same way that the patient does. Since the patient is the one with the first-hand experience of the illness in this case, they can offer expertise in the consultation that the doctor cannot. Even if the doctor has suffered from the same ailment as the patient, the lived experience of the illness will differ between individuals, thus meaning that as much as a doctor can attempt to understand what the patient has been going through, they cannot fully comprehend every detail of the problem. Hence the expression of empathy is created though the medical student being open with the simulated patient, and acknowledging this limitation.

9.1.3. Interest Taking

In this scenario, the interactional mechanisms involved in taking an interest consist of opening the floor up to the simulated patient with an open-ended question, thus allowing them to explore the issues which are most salient to them:

(90) [010]

20	Student:	oh (.) okay (.) and um (.) your age
21	Patient:	i'm fourty two
22	Student:	your fourty two (0.5) okay (.) thank you
→ 23		very much (.) and now if you could just
24		begin by telling me a bit about what's
25		been happening to you

(91) [014]

20	Student:	>hello is it< miss saunders
21	Patient:	yeah
22	Student:	hi um the GP's asked me to see you today
23		(.) um i understand you've (.) been having
→ 24		some problems and um (.) i just really
25		want to find out a little more about that
26		if that's okay
27	Patient:	that's fine yeah=

Through the use of this strategy, it is the simulated patient's agenda, and not the medical student's agenda which becomes the focus of the consultation. By opening the consultation up in this manner, the medical student is allowing the simulated patient to contribute to the agenda, and ensure that the focus of the consultation is relevant to the simulated patient's needs. Hence, the medical student is taking an interest in the simulated patient's personal preferences toward the content and information to be given in the consultation, which in turn acts as a method of empathetic expression. Furthermore, the medical student also takes an interest in the simulated patient through the responses to information given about the simulated patient's private life:

(92) [008]

73	Patient:	i-i'm a book binder and [printer
74	Student:	[oh okay (.) uh
75		interesting
76	Patient:	yeah
→ 77	Student:	do you en↑joy it
78	Patient:	oh very much yeah (.) yeah (.) and i can
79		work from home and uh (0.5) y'know w-
80		business is good at the moment so (.) yeah

(93) [009]

23	Patient:	um actually got my own business er (.)
24		business book binding and printing
25	Student:	o[kay
26	Patient:	[°display° at the (.) bottom of the garden
27		really and=
→ 28	Student:	=that's ↑really interesting
29	Patient:	↑yeah it's it's a nice er (.) nice (.)
30		place to work y'know (.) nice way to work

By following up in this manner on personal information given to the medical student, it amplifies cooperation and politeness in the interaction. In both examples, the medical student shows that they wish to learn more about the simulated patient – not just from a medical perspective – but from a humanistic one too: the student is treating the patient as a person, not a 'case'. This enhances the positive face (Brown and Levinson, 1987) of the simulated patient, as through these utterances (example 92, line 77 and example 93, line 28), the student is demonstrating that the action of the simulated patient telling the student about their occupation is desirable to them. Thus it can be seen that by taking an interest in the simulated patient, the student can enhance the patient's positive face, and also learn more about what the patient wants from the consultation, then tailor the consultation to these wants.

9.1.4. Agreeing

There are instances coded as being empathetic expression in the data where the medical student would agree with the simulated patient's opinions, statements and concerns about the illness:

(94) [012]

176 Patient: [yeah that's yeah sort of
177 protrude out yeah
→ 178 Student: yea s-s-not the nicest thing
179 Patient: no (.) it's a bit (.) embarrassing (1.5)
180 as you can imagine

(95) [013]

218 Patient: i don't quite know what's going on
→ 219 Student: yeah i appreciate that yeah (.) but
220 nonetheless they are still things you can
221 try even though y'know (.) the IBS
222 probably brings it out of your hands
223 slightly

224 Patient: <yeah> do you think (.) the IBS might be
225 part of the cause of it

(96) [013]

307 Student: and (.) um (2.0) most people that (.) that
308 works on (.) but it's got a ss-slightly
309 lower >sort of< success rate so again it
310 could have it it's in the region on sixty
311 seventy percent ( ) so they're two
312 types of surgery then there's a third one
313 where you can sort of bend them away
314 slightly as i say

315 Patient: it sounds quite painful

→ 316 Student: £yes it does sound painful i agree£ but um
317 (.) down there there's not much sensation

This enhances the simulated patient's positive face (the desire for wants and needs to be desirable to others (Brown and Levinson, 1987)), as the effect these statements have is to verify the simulated patient's thoughts, and thus have them accepted by others. However, this strategy must be used with caution. The following example is from a medical student whose first language was not English, and it is assumed that this contributed to their unorthodox use of the term 'dignified':

(97) [015]

202 Patient: i think the whole thing's a bit
203 embarrassing (.) really

→ 204 Student: of course it's not a very dignified[

205 Patient: [no exactly

206 Student: [examination (0.5) unfortunately in order
207 to find out what is actually going on
208 especially when bleeding is involved it's
209 best to have it done

While the medical student is agreeing with the simulated patient, it is argued here

that they are actually doing so in a negative manner. The term ‘dignified’ is socially desirable characteristic to the patient, and therefore, the medical student suggesting that having haemorrhoids is not very dignified could act as a direct threat to face (suggesting the patient is undignified because they have this ailment). However, the role-player still coded this act as empathetic, and this may be due to it being the medical student’s effort to empathise with the simulated patient (as interpreted by the simulated patient), rather than the actual empathising itself. Hence it is the effort, rather than the content, which is desirable to the simulated patient. Had it been another role-player who did not comprehend the language difficulties and confusion, then this utterance may have been interpreted in a more negative fashion. Hence, while agreeing with the simulated patient can enhance their positive face, the register, and subsequent words used must be considered in order to ensure that the simulated patient understands the agreement in the intended manner.

9.1.5. Suggesting

Making suggestions was another strategy employed by the medical students which was deemed to involve empathetic expression. However, unlike the previous examples which predominantly concerned positive face, making suggestions involved negative face (the desire to be unimpeded by others). The nature of the medical consultation dictates that the patient’s negative face will be impeded at some point if the doctor is to give information. It is obvious that when a patient goes to see a doctor, they want their negative face impeding to some extent: they want to be told what to do by the doctor. This is not always the case (for example, when a doctor would use motivational interviewing for smokers who need encouragement to give up); however, the doctor making suggestions is a common occurrence in the medical interview. For example:

(98) [013]

→ 247 Student: have you tried one of those >sort of< ring
248 cushions i’ve heard=

247 Patient: =well hhh. i have uh (.) because uh um my
248 husband and i have a business at home >a
249 book binding business<

Here, the medical student can be seen to be suggesting that the simulated patient try a ring cushion to alleviate their pain. Rather than explicitly state using a declarative sentence 'I think you should try a ring cushion', the medical student instead employs an interrogative sentence, asking the simulated patient whether they have already tried the student's suggestion, and this lessens the threat to the simulated patient's negative face. The threat to negative face when making suggestions to the simulated patient may also be mitigated through prefacing any utterance with a warning that the simulated patient will potentially suffer loss of face:

(99) [012]

→ 299 Student: okay (.) um (.) so the other thing is >and
300 this might< be a bit embarrassing but (.)
301 it's just us here so you don't have to
302 feel embarrassed at all

303 Patient: okay

304 Student: and it's completely natural (.) once you
305 go to the toilet (.) when you get the urge
306 to go

307 Patient: yeah

308 Student: don't resist the temptation (.) to hold it
309 in >i mean< don't hold it in

Here, the medical student is aware that they are about to make the simulated patient feel an undesirable emotion, and therefore, they warn the simulated patient of this beforehand to mitigate the threat to their negative face, which, importantly, was coded as an empathetic act by the medical student, simulated patient, and researcher. Although this warning does not remove the threat to face, it does serve as a warning, and therefore a showing on the medical student's part that they appreciate the patient's predicament and potential for embarrassment, and are making a conscious

attempt to make the patient feel more comfortable. Thus, it can be seen that while making suggestions potentially threatens the simulated patient's negative face, it is a vital aspect in the medical consultation, and, when handled in the correct manner, can be deemed to contribute to empathetic expression.

9.1.6. Use of 'I'm sorry to hear that'

Another strategy which was deemed empathetic was for the medical student to utilise the phrase 'I'm sorry to hear that'. Experts suggest that this relates to the concept of sympathy more than empathy, although may be deemed what is termed 'reactive empathy' (Stephan and Finlay, 1999). The phrase has a variety of functions within the consultation. For example:

(100) [014]

44	Patient:	well it was the bleeding that worried me
45		(.) more than anything else but over the
46		last six months since then (.) it's just
47		been (.) excruciating i can't tell you
→ 48	Student:	ah i'm sorry to hear that (1.0) uh is
49		anything that make it better >or worse< at
50		the time
51	Patient:	well (0.5) nothing seems to make it much
52		better to be honest i've i've start[ed cos
53		i work at home

In this example, the phrase 'I'm sorry to hear that', has the effect of transferring control of the floor from the simulated patient to the medical student, while at the same time mitigating the threat to the simulated patient's face. The one second gap following the utterance on line 48 demonstrates this transfer of power; it may have otherwise been deemed a transition relevance point, but the simulated patient's disinclination to interject leads to the medical student maintaining control of the floor. This could be considered a good strategy to interrupt the patient if they are holding the floor excessively or going off topic in the consultation. However, the use

of the utterance ‘I’m sorry to hear that’ does not always serve this function. Take the following for example:

(101) [007]

321	Patient:	if i go to the toilet (0.5) and um on ˚˚on
322		the paper˚˚ (.) and um (2.0) it’s just
323		unfortunate really that my dad um (1.0) he
324		had ˚bowel cancer˚ (.) and um (.)
→ 325	Student:	˚˚˚sorry to hear [that˚˚˚
326	Patient:	[i mean it’s (.) yeah (.)
327		thank you (.) i mean it’s some years ago
328		now but unfortunately we (.) he had an
329		operation but we did lose him and he was
330		only in his early sixties (.) and i think
331		it just stays with you

Contrary to the previous example where the utterance ‘I’m sorry to hear that’ allows the medical student to obtain the floor, here its utilisation does not serve that function. In the first part of the sequence, the simulated patient’s use of ‘and’ indicates that they wish to hold the floor. However, the student interjects, with ‘I’m sorry to hear that’, although this is a muffled, almost whispered utterance. Before the medical student manages to finish the utterance, the simulated patient overlaps, and proceeds to carry on with their stream of thought from the first part of the sequence. They do acknowledge that the medical student has ‘apologised’ for their misfortune with a ‘thanks’, but this does not stop them from holding the floor. Another, more extreme example of this can be seen in the following:

(102) [015]

321	Patient:	um well my dad (.) he had uh problems with
322		his bowel (.) he had bowel cancer
→ 323	Student:	i’m so sorry to hear that
324	Patient:	um and he had an operation when he was
325		sixty (2.0) um (0.5) and it seemed to go
326		well at the time but unfortunately (.) um

327 he (.) eighteen months later he did (.)
328 pass away

329 Student: i'm so sorry

330 Patient: so um (1.0) that has been a bit of a worry

Here, the use of 'I'm so sorry to hear that' is completely ignored by the simulated patient on an interactional level, thus the floor is held by the simulated patient. This is shown by the uttering of 'i'm so sorry' on line 323, and the patient's (lack of) response on line 324, which essentially involves the patient continuing their topic from line 321-322. Moreover, the student then proceeds to try the same technique on line 329 'i'm so sorry', but again, this leads to a breakdown in communication, with the patient false-starting on line 330 'so um', and then a silence (1.0). Interestingly, despite this breakdown in communication, the above act was deemed empathetic by all three parties who were involved in the coding process. It may be concluded that the use of 'I'm sorry to hear that' in relation to the simulated patient's misfortune can function as a strategy for taking the floor from them; however, in many cases, this utterance can be ignored by the simulated patient in terms of the interaction but is still considered an empathetic act, even when there is no indication of this in the following communicative sequences. The fact that these sequences were coded as empathetic shows that while the utterances were not directly responded to in the consultation, they were still deemed to function as an empathetic expression.

9.1.7. Positive Proclamation

Positive proclamation refers to the elements in the consultation where the medical student produces a positive statement regarding the future progression and treatment of the disease. For example:

(103) [006]

551 Student: n that's something now you can discuss and
552 have a think about what option would be
553 best for you

554 Patient: alright

→ 555 Student: so i hope that's been helpful

556 Patient: yeah very helpful (.) thank you

(104) [011]

438 Student: okay well um (0.5) i'll pass on a-all that
439 information for you ( ) if that's okay

440 Patient: yeah

→ 441 Student: and GOOD LUCK (.) i hope you er (.) get it
442 sorted [soon

443 Patient: [thank you very much (.) thank you

(105) [012]

412 Student: try that and come back in a few weeks and
413 see how that's getting on for you

414 Patient: okay

415 Student: well thank you very much for coming in
→ 416 today (.) um i hope that's helped

417 Patient: yeah thank you

This offers personal reassurance for the medical student that the consultation was good and useful for the simulated patient. However, all three of the above examples were *only* coded as empathetic expression by the simulated patients, hence this could be deemed a deviant case in relation to the rest of the data. Neither the researcher, nor any of the medical students deemed a positive proclamation to be an empathetic act in any of the coding, but both simulated patients coded positive proclamations as empathetic each time the technique occurred in the data. It appears that this may be confusing the interpretation of empathy with general politeness principles, although it could be argued that a positive proclamation is a form of empathetic expression, as it demonstrates that the medical student has understood the simulated patient's desire to get better. Therefore, it could be argued that this is a more basic form of empathy

(namely being polite and courteous), and is a potential area for further work not just within medical education, but sociology as a whole.

In conclusion, the following strategies were deemed to be empathetic, with many serving multiple helpful functions within the consultation.

- Offering the patient both material items and emotional assistance enhances their positive face.
- Praising the patient offers reassurance that the disease is not their fault.
- Taking an interest links to enhancing positive face, and learning what the patient wants from the consultation.
- Agreeing can enhance positive face, but the context in which it is used must be taken into account.
- Suggesting can threaten negative face, but by using an interrogative structure, rather than declarative, this threat can be mitigated.
- Apologising to the patient can act as a method of taking the floor from them, while still appearing empathetic to their cause.
- A positive proclamation is sometimes deemed to be empathetic.

9.2. AGENDA SETTING

Management of the agenda was deemed to be a central element in the perceived expression of empathy. This included the elicitation of the simulated patient's agenda, relevance of the medical student's own agenda, the medical student checking for other issues and future action to be taken.

9.2.1. Patient Agenda

The traditional medical consultation involves the doctor in a position of power over the patient (Pilnick and Dingwall, 2011). This is due, in part, to the professional position of the doctor over the patient. In a traditional medical consultation, the doctor is the expert, and the patient is wishing to draw on this expertise, hence putting them in a weaker position with regard to the power balance. In other words,

the doctor has something (knowledge) that the patient wants. Other socio-economic factors also contribute to the doctor's power over the patient. For example, the fact that the doctor conducts consultations on a daily basis makes them more familiar with the conversational routine, or that the patient may be very concerned about their illness, and hence be unnerved by the whole process of going to see the doctor. Evidently, this power balance is somewhat blurred by the fact that the doctor is employed by (and hence accountable to) someone, whether it be by the NHS or a private healthcare group; however during the consultation, the doctor has a clear advantage in terms of the power relations between the two. In contrast to this, in a number of cases shown in the data, the medical student actively transfers the balance of power to the simulated patient in the consultation; for example:

(106) [001]

67 Patient: i really want to get them (0.5) sorted out
68 (.) if i can

69 Student: °certainly (.) okay° so we'll discuss the
70 treatment options now um and if there's
71 anything else you want me to go through
→ 72 just stop me (.) if you don't follow
73 everything just stop me

74 Patient: okay

(107) [002]

23 Student: um are you sitting comfortably

24 Patient: ish

→ 25 Student: okay well if you do want to stop at any
26 time do just let me know okay=

27 Patient: =okay

(108) [003]

23 Patient: i am a bit uncomfortable (.) no i just if
24 i just
25 position myself or thhh

26 Student: sorry i should have asked before (0.5) um
→ 27 (.) do tell me to stop if you're (.)
28 uncomfortable at
29 any[time
30 Patient: [okay (.) thank you

In each of the above examples, the medical student is offering the simulated patient the opportunity to interrupt him or her at any point in the consultation in order to pursue their own agenda. This has a two-fold effect which relates to the negative faces (the desire to be unimpeded (Brown and Levinson, 1987)) of each interlocutor. By producing an utterance of this type, the medical student is sacrificing his or her own negative face, as they are inviting themselves to have their own agenda impeded by the simulated patient. Moreover, the effect this has on the simulated patient is to give them an element of control in the consultation, in the process enhancing their negative face: their desire to be unimpeded, and thus discuss what they want to discuss. It provides them with an opportunity if they are in pain, or have not understood something, to address these issues. Hence the empathetic content here appears to relate to the medical student making a sacrifice to their negative face in order to better understand the wants and needs of the simulated patient. This said, the felicitousness of the speech acts must be considered: a doctor can say that they are happy for the simulated patient to interrupt them, but in practice, they may not provide the patient the opportunity for this or the patient may not attempt to interrupt. However, in the cases listed above, the opportunity provided by the medical student for the simulated patient to interrupt was interpreted as an act of empathetic communication, regardless of the actual realisation of this later in the consultation.

Another example of the transfer of power from the medical student to the simulated patient is when the student lets the simulated patient set the agenda in the following examples:

(109) [008]

→ 57 Student: okay (.) um and so (.) today what are you
58 expecting (.) from our (.) consultation

59 Patient: well i mean i'm really just hoping (0.5)
60 that you know you can advise me on um (.)
61 the best way forward >i mean i'm-i'm<
62 getting so desperate now i really would go
63 for quite drastic treatment

(110) [012]

→ 88 Student: okay (.) so (.) what would be most useful
89 for me to go through with you (.) today

90 Patient: if you could tell me what that means and i
91 suppose (.) why i've got them and what i
92 can do about them (.) and is there
93 something i can do just to (.) clear them
94 up

(111) [009]

336 Student: and he can talk to you (.) when we've got
337 more time

338 Patient: alright

→ 339 Student: or would you RATHER we talked about it now
340 >it's completely up to you<

Unlike the previous examples, these involve the medical student offering the simulated patient the opportunity to set the agenda, rather than interjecting as before. Through this transfer of power, the medical student is again potentially sacrificing his or her negative face (their desire to have their own medical agenda unimpeded by the patient) while at the same time mitigating any threat to the patient's negative face. In addition to the aspects of face, Grice would consider these examples to abide by the relevance maxim (Grice, 1975: 78-79): by asking the simulated patient what they want from the consultation, the medical student is ensuring that whatever they do then proceed to discuss will be relevant to the simulated patient's needs, and this

is shown by the patient's response in both examples 109 and 110. Evidently this is not always the case, as there are times when a patient may be reluctant to reveal their true motive for seeing the doctor. For example, the simulated patient from the scenario in this research was concerned about bowel cancer, but did not initially divulge this to the doctor. Hence while handing the balance of power to the patient does allow them to pursue their own agenda to an extent, it must be remembered that the patient may not initially wish to, or feel able to, disclose their true agenda. Again, the perceived empathetic content in this case appears to surround the medical student potentially sacrificing face to meet the simulated patient's needs, but also giving the simulated patient the opportunity to follow their own agenda in the consultation.

9.2.2. Relevance of Doctor's Agenda

There were cases identified as empathetic expression where the doctor checked the relevance of their own agenda against that of the patient, and this is shown in the following examples:

(112) [002]

47 Student: okay (1.5) right (.) cos er what i'd like
→ 48 to do in our discussion if it's alright
49 with you (.) is um (.) just start from the
50 beginning really (.) um check that you're
51 (.) sorry are you alr↑ight there

52 Patient: thhhh yeah

(113) [007]

47 Student: i um (.) yeah i can imagine it's not a
48 very nice (0.5) thing to have so (.) and
49 now you're thinking about the next step
50 for (.) some sort of treatment is that
51 right

52 Patient: i hope so yeah

→ 53 Student: um (.) is that what you've come in to talk
54 about (.) today

These examples differ from those involving the simulated patient setting the agenda. While the simulated patient is still involved in the agenda setting process, it is actually the doctor who is driving forward the content of the consultation. Particularly with the first two examples, the use of the first person pronoun indicates that the doctor is in control, and that the agenda is his or hers to set. However, this power is disguised to an extent through the use of the conditional sentence. When the medical student asks '`if it's alright with you`' on line 48, they are not asking a direct question of the simulated patient, but merely making it appear as though they are transferring power to them (it could be assumed that they are expecting the simulated patient to say 'yes' to this question). Hence this may be a useful strategy for appearing empathetic and involved with the simulated patient's wants and needs, while still pursuing the doctor's agenda.

Building further upon this, elements of the consultations which were coded as empathetic related to making a shared decisions with the simulated patient:

(114) [009]

```
272   Student:  it sounds to me like you just want to (.)
273             put all this behind you

274   Patient:  oh definitely (.) kind of a phrase

275   Student:  yeah so (0.5) i think (.) from what you've
→ 276           told me to sounds like we should move onto
277             the third stage of the treatment which
278             would be the outpatient procedure

279   Patient:  right
```

Here, the use of the first person plural 'we' is indicative of an attempt to include the simulated patient in the decision making process, and this has the effect of enhancing the positive face of the simulated patient. By including the simulated patient in the process, the medical student is accepting the wants and needs of the simulated patient. Despite this, the doctor still holds the power here, as he or she is moving the

agenda along in accordance with personal preferences. This is also apparent in the following:

(115) [006]

120	Patient:	yeah (.) and i mean i (.) I S'POSE i am
121		quite worried about >sort of< bleeding
122		from down there
123	Student:	yeah of course (.) yeah
124	Patient:	i mean it could be anything °couldn't it°
→ 125	Student:	yes it can but hopefully yeah i can talk a
126		bit more about bleeding as well and
127		hopefully reassure you about that

The use of the modal verb 'can' suggests that the simulated patient is being given a choice about what they would like to include in the agenda; however, in reality, it is unlikely that the patient would dismiss this. Therefore, it could be argued that the doctor can be perceived to be expressing empathy by appearing to include the patient's wants and needs in the consultation, even if these inclusionary statements are somewhat untrue.

9.2.3. Expanding the Agenda

In addition to the above, a medical student may invite the simulated patient to add to, or expand upon, the agenda once the previous aspects of it have been covered: 'are there any questions that you want to ask me at ↑all' (005, line 313); 'do you have any more questions about any of them' (007, line 371); 'we've got time for questions' (009, line 371). Grice might argue that this is an attempt by the medical student to abide by the quantity maxim (Grice, 1975: 78-79). By asking the simulated patient if they have any questions, the medical student is attempting to cooperate with the patient's wants and needs, and ensure that the information given to them is sufficient. Another point to make here is that the medical student uses the lexical item 'questions', rather than

asking more broadly about ‘issues’. This makes it more specific and could be seen as an attempt by the medical student to avoid digression in the consultation, thus meaning that the medical student maintains the power, but is seen to be including the simulated patient in the agenda setting. Overall, the empathetic aspect here is making sure that the simulated patient’s wants and needs have been met as fully as possible in the agenda.

9.2.4. Future Action

Future action in the consultation refers to the treatment regimen the doctor recommends, as well as the follow up and next steps for the patient once they have left the consultation. Due to the fact that the data collected involved medical students, a lot of the students claimed that they would pass on the concerns of the patient to the doctor, while others played a ‘fuller’ role as a doctor. In many cases, the student made reference to rectifying the problems that the simulated patient was having:

(116) [003]

```
65   Student: okay (.) well °sure sure° it must be
66              painful[
67   Patient:           [mmm
→ 68 Student:  um (.) alright well >we'll we'll< really
69              try and get something (.) sorted out=
```

(117) [004]

```
88   Student:  of course so it's having quite an impact
89             on your life interfering with ↑work and
90   Patient:  definitely yeah
→ 91 Student:  so i can see we (.) ought to get this
92             sorted for you um
```

(118) [009]

357 Patient: uuum (0.5) well it's just on the toilet
358 paper=

359 Student: =just on the toilet pa[per

360 Patient: [sss quite bright
361 (.) red yeah

362 Student: °°probably° (.) it does sounds relatively
363 unlikely (.) although if you're worried we
→ 364 can (.) certainly arrange further
365 investigations to

Evidently, the simulated patient will want to get any problems sorted, as that is presumably why they are seeing the doctor. It could be argued that the concept of face (Brown and Levinson, 1987) is connected with this strategy, as the doctor is attempting to meet the wants and needs of the other, and it is the expression of this understanding here that invokes the empathy, shown by the students' final turns in each of the above examples. In addition to this, the time between leaving the consultation and the problem being sorted was also addressed:

(119) [012]

396 Student: um we've gone through a lot today (.) and
→ 397 it is a lot to take on (.) if you've got
398 any other worries don't hesitate to come
399 back and have a chat with us

400 Patient: oh right

(120) [014]

→ 389 Student: and if and if in the meantime while you're
390 waiting for this referral the pain gets
391 (.) excruciating if you come back there
392 are more things that we can give you to
393 try

394 Patient: to try and help

Similarly to allowing the simulated patient to interject in the consultation, the doctor is potentially sacrificing their negative face here by offering the simulated patient an opportunity to come back. Furthermore, in example 120, the medical student is also considering temporary measures in order to make the simulated patient more comfortable while they wait for referral. In other cases, the medical student ends the consultation by informing the simulated patient that information will be passed on to other parties:

(121) [001]

→ 167 Student: _____ mmk i (.) i will ss-certainly flag
168 up your concerns with the doctor (.) and
169 um (.) um i think i-it's reasonable (.) to
170 assume that you'd like this treated [as
171 soon as possible

172 Patient: [yeah
173 (.) yeah

(122) [014]

352 Patient: um (0.5) but i would really like to have
353 something (.) you know (.) quite positive
354 done i think [to make them go away

→ 355 Student: [well okay (.) how about we
356 fff-i speak to the GP

357 Patient: yeah

(123) [009]

352 Student: i think that's (.) that-d ju- a special
353 decision to make really (.) that's not
354 really something that i can (.) comment on

355 Patient: yeah

→ 356 Student: but i would recommend you go and speak to
357 the (.) >°°consultant°°<

The perceived empathy here stems from the medical student's understanding of the

simulated patient's needs not just in the long term, but also the short term. It relates to the medical student giving the simulated patient the option of coming back if necessary, and the confidence that what they have discussed in the consultation will be passed along to the relevant parties, to further assist with their care.

Agenda setting appears to be an integral part of what is perceived to be empathetic expression, and the aspects which were deemed to contribute to the expression of empathy in this scenario are summarised as follows:

- Telling the patient to interject if they deem it necessary.
- Allowing the patient room to set the agenda.
- Making the doctor's agenda appear as though the patient is running it.
- Checking the doctor has covered as much as he or she can with regard to what the patient wants from the consultation.
- Considering what will happen to the patient after they leave the consultation, both in the long term, and the immediate future.

9.3. CHECKING UNDERSTANDING

Trying to understand the patient's thought processes and feelings was raised as one of the key constituents of expressing empathy by the focus group, and was coded as such in the data by all parties. In these instances, checking understanding referred to the medical student actively checking the simulated patient's understanding of the explanations of symptoms and treatments, checking the medical student's understanding of the simulated patient's explanation of the illness, and attempting to understand the simulated patient's thought process and prior knowledge about the disease. This reciprocity therefore appears to be core to the expression of empathy, as it ensures that the simulated patient has understood the medical student, and that the medical student has understood the simulated patient.

9.3.1. Understanding of Doctor's Explanation

One of the most frequently used methods involved in checking understanding was for the medical student to simply ask the simulated patient about whether they had understood the information given to them up to that point:

(124) [013]

98 Patient: so how bad could they ↑get then

99 Student: um (.) they get graded up to four

100 Patient: right

101 Student: and um (0.5) and the moment it (.) the
102 grade tier is saying that yours can be
103 pushed back but th-they generally come out
104 quite a lot and they're causing (
→ 105) (0.5) does that make sense

(125) [001]

280 Student: okay (.) so if tt i just want to make sure
281 i've given the right message ↑to you (.)
→ 282 what do you understand as the main er what
283 could what do you think you could do urm
284 in terms of prevention

285 Patient: um (.) drink more water

286 Student: °↓m↑hmm°

(126) [006]

321 Student: so um (.) i know i explained a lot to you
322 there

323 Patient: mm

→ 324 Student: has everything that i've said so far (0.5)
325 ↑made ↓sense (.) is th[at

326 Patient: [no no it's very
327 clear thank you

Asking if a patient has understood information may be seen as a face threatening act, as it could be argued that the doctor is essentially questioning the patient's intellectual capacity for absorbing and understanding the information given to them, although it is an essential part of the information giving process to ensure comprehension of vital knowledge. In the second and third example here, this threat to face is mitigated by the doctor; the use of the first person pronoun shifts the onus onto the doctor. Rather than asking the simulated patient outright 'have you understood', the medical student makes it sound as though he or she would be at fault if the message has not been conveyed proficiently and understood by the simulated patient. By doing this, the medical student is increasing the risk to his or her own face, while minimising the risk to the simulated patient's face.

Further to this, the medical student may also check if the simulated patient is satisfied with the information given to them, as well as their understanding of it: 'you're happy with that' (008, line 343); 'are you happy with that' (015, line 287). Grice may consider this strategy as the medical student attempting to abide by the quantity maxim (Grice, 1975: 78-79), as the utterances could be interpreted as the simulated patient not just understanding the information given, but also that they are satisfied that they have been given enough. It may also be construed to relate to the psychological aspects around the illness: how the simulated patient feels about having the illness. Examples of summaries of what the doctor had discussed previously were less frequently coded as being empathetic in the text.

9.3.2. Understanding of Patient's Explanation

It is vital for the medical student to check that what they have said to the simulated patient has made sense, but it is equally crucial for the medical student to comprehend what the simulated patient is telling him or her about the lived experience of the illness. The main way that this was achieved was for the medical student to repeat the information back to the patient which the latter had just given to the doctor, and then ask whether this was accurate.

(127) [008]

81 Student: okay (.) so if i can just sort of (.) uh
82 just so i KNOW myself what's been going on
→ 83 (.) if i could just (.) say what you >sort
84 of< told me and you can let me know if i
85 get anything wrong (.) so (.) do you say
86 it's been going on (.) it's been really
87 bad for six months <°now°> but it had been
88 (1.0) [eh

89 Patient: [it started to (.) be more sort of
90 regular (.) this thing (.) y'know uh of
91 (.) discomfort [sitting down

92 Student: [yeah

(128) [014]

37 Patient: and um (1.0) and so basically today i've
38 just come back to have a talk (.)
39 hopefully have a chat about y'know what
40 the next steps are [really

41 Student: [okay (1.0) okay (.) um
→ 42 (.) so for the last six months (.) you've
43 been having pain

44 Patient: well it was the bleeding that worried me
45 (.) more than anything else but over the
46 last six months since then (.) it's just
47 been (.) excruciating i can't tell you

(129) [016]

58 Patient: um (.) really i've (0.5) i suppose for a
59 year or two but it's got really bad in the
60 last six months=

→ 61 Student: =okay (.) bleeding started six months ago
62 is that right

63 Patient: yeah (.) YEAH didn't really notice it just
64 happens all the time now

This serves two main functions with regard to the empathetic content. Firstly, it allows the simulated patient to add to the information that has been given to them up to that point in the consultation, which Grice would consider as abiding by the quantity maxim (Grice, 1975: 78-79); if the patient has not been able to give all the information they wanted to up to that point, then without the student using the above techniques the maxim would be flouted, and potentially important information could be missed by the medical student. Secondly, it permits the simulated patient to correct any information that the medical student has interpreted incorrectly. Hence, the empathy here is derived from the ambition of the medical student to effectively 'double check' they have understood the patient's explanation and give them the opportunity to ensure that what the medical student understands to be true is an accurate representation of the patient's thought process. Note that this differs from the type of summarising mentioned previously, as it is about the simulated patient's description of the illness, rather than a summary of what the medical student has told the simulated patient.

9.3.3. Understanding of Patient's Thinking and Knowledge

As well as understanding the simulated patient's explanation, understanding the simulated patient's thought processes and prior knowledge about the illness was also deemed central to empathetic expression. This is particularly in relation to worries and concerns about the illness:

(130) [008]

118	Patient:	so it's no wonder i've got (.) diarrhoea
119		and then suffer constipation y'know and er
120		(1.0) i suppose that must relate to i mean
121		can you tell me a bit about why [i might
122		have
→ 123	Student:	[yeah is
124		that (.) is that your idea about why you
125		might have got haemorrhoids (.) [do you
126		think it's to do with the IBS

127 Patient: [um (.) i
128 think it must be associated with something
129 to do with that (.) yeah

(131) [009]

306 Patient: yeah (.) i mean you don't think i-it's a
307 sign of anything worse >i mean obviously
308 when you see blood coming out of your back
309 passage< it's quite worrying

→ 310 Student: mm (.) w-well why d'you think it would be
311 worrying

312 _____

313 |

314 (2.5)

315 |

316 Patient: _____ well i (.) my dad had um (.) sort
317 of (.) bleeding from his back passage and
318 it turned out to be bowel cancer

(132) [010]

306 Patient: well my (.) um my dad had bleeding from
307 his back passage and uh (.) it turned out
308 he had bowel cancer

→ 309 Student: right (1.0) okay (0.5) and is y'know is
310 this something that concerns you

311 Patient: well you know obviously yeah (.) it didn't
312 work out very well for him (.) i mean

This is useful for the medical student to obtain a better understanding of the simulated patient's thoughts and feelings towards the illness, and how this may affect their receptiveness to certain treatment regimen. However, it must be remembered that in many cases, the patient may not divulge the whole truth, or even lie (for example, when asking if a patient takes any illegal drugs). Therefore, it is

important for the doctor to follow up on the questions depending on the patient's response, especially when the response is purposely ambiguous, and, as Grice would say, violates the manner maxim (Grice, 1975: 78-79). In example 131, the patient is ambiguous, and avoids divulging their true concerns from lines 306-309, but does hint at them, with statements about it being '`a sign of anything worse`' and a statement about it being '`quite worrying`'. The medical student then follows up on this, and asks '`w-well why d'you think it would be worrying`' on line 310. This leads to a long pause (2.5 seconds), before the patient finally reveals that their father suffered from bowel cancer. Hence it is important that the medical student does not merely ask about the simulated patient's thoughts and feelings, but follows up any ambiguity with further questions to get to the real concerns of the simulated patient.

Checking the simulated patient's knowledge about a disease or starting point was also coded as being an act of empathetic expression. For example:

(133) [013]

306 Student: so (.) um (.) we've that >k'now< you've
307 got these haemorrhoids y-you've had an
308 investigation confirmed that they are them
309 (.) um (.) ssso before we (.) move on to
310 talk about possible treatments (.) um do
→ 311 you understand what the treatments are (.)
312 or not at all or

313 Patient: um (.) i've heard of people having
314 operations and um

315 Student: okay

316 Patient: and that kind of thing (.) umm no the
317 consultant just said to talk to the GP
318 about it

(134) [012]

→ 306 Student: um (.) you ss understand it's something
307 about veins is that right

308 Patient: yeah well blood vessels i think yeah

309 Student: well that's absolutely right

Grice would argue that these utterances are acting as a preface to the quantity maxim (Grice, 1975: 78-79), as through the medical student obtaining information about what the simulated patient already knows or does not know, he or she is in a better position to give the correct amount and type of information to the patient, thus ensuring that the consultation is more patient centred, and thus instilling greater empathy (showing greater understanding of the patient's thoughts and feelings). This also saves valuable time in the consultation, both for the medical student and simulated patient, as it gives them more time to pursue their own individual agenda.

The strategies for how checking understanding is perceived to be involved in the expression of empathy have been discussed here, and the main conclusions to be drawn surrounding what the doctor can do to promote this are as follows:

- Check that the information given to the patient has made sense to him or her.
- Check that the right amount and type of information has been given to the patient.
- Summarise the patient's explanation to allow him or her opportunity to change or add anything.
- Do not only ask about the patient's feelings, but probe further if there is ambiguity to discover underlying issues or concerns.
- Check the patient's starting point, as it saves time for both parties to pursue their agenda further.

9.4. INFORMATION RETENTION AND ATTATCHMENT OF CONDITION

The medical student's ability to retain information about the simulated patient, and then utilise this information to relate the disease to the lived experiences of that patient, was another commonly perceived act involved in empathetic expression. More specifically, asking about previous symptoms and treatments, and the support

and future treatment regimen were all elements involved in this. Another commonly used sequence, coined ‘state then relate’ was also apparent throughout the coding.

9.4.1. Previous Symptoms and Treatments

Anaphoric referencing occurs when a linguistic entity ‘indicates a referential tie to some other linguistic entity in the same text’ (Tognini-Bonelli, 2001: 70), or, in this case, the same consultation. This contributes to the creation of empathy, as it allows the doctor to demonstrate to the patient that they have listened to them, and taken their views, ideas, concerns and expectations into account. This is particularly salient where the patient has told the doctor something which becomes relevant as the consultation progresses. Through the initial acquisition of the information and subsequent referential adequacy, the doctor indicates to the patient that his or her worries and concerns have been understood.

There are many factors which may contribute to the necessity for referential adequacy, ranging from the disease that is being discussed, to the patient’s capacity to understand the information being given to him or her. The scenario chosen has a number of examples which relate to this. The link between haemorrhoids and IBS is frequently discussed in the consultations, and was perceived to be empathetic. It occurred when the medical student referred back to information that was given previously to the simulated patient in the consultation, or information from a previous consultation with another healthcare professional (for reasons of practicality, excerpts of these are not included here, as the space between them would be too vast, but as stated earlier, all transcripts can be found with the accompanying materials). Referring back is apparent in transcript 006, where the patient reveals on line 39 that they have suffered from IBS. The medical student then proceeds to refer back to this on line 248 ‘so that could be one of the link with your IBS’. This technique also occurs in transcript 012, where the patient reveals they have suffered from IBS on line 47, and refers back to this on line 114, and in transcript 008 where IBS is referenced on lines 112-114 and referred back to on line 270. It also occurred spontaneously in the consultation, within the same communicative sequence. For example, in example 135, on line 114 the simulated

patient reveals that they have IBS. This utterance is shortly followed on line 125 by the medical student making connections between this information, and why they have come to see the doctor:

(135) [008]

112	Patient:	well the thing is er (.) i've had (.) what
113		i (.) realised about eight years ago is
114		IBS
115	Student:	right
116	Patient:	um (.) had that for about twenty years
117	Student:	°°oh gosh right°°
118	Patient:	so it's no wonder i've got (.) diarrhoea
119		and then suffer constipation y'know and er
120		(1.0) i suppose that must relate to i mean
121		can you tell me a bit about why [i might
122		have
123	Student:	[yeah is
124		that (.) is that your idea about why you
→ 125		might have got haemorrhoids (.) [do you
126		think it's to do with the IBS

Hence it can be seen that the referential adequacy associated with the expression of empathy can emerge from previous sequences in the consultation, or another consultation, as well as within the same communicative sequence.

Another example of the doctor referring back to previous and related symptoms occurred with the explanation to the simulated patient about the grading system, which is used to determine the severity of the ailment. In 012, on line 40, the simulated patient reveals that they have been suffering from grade two haemorrhoids. Rather than go into the explanation immediately, the medical student refers back to this knowledge and offers an explanation as to what this means later in the same consultation on line 171:

(136) [012]

→ 171 Student: and um (.) what grade two means is (.)
172 that (.) they're there (.) um and
173 sometimes they'll actually come out

In this case, the medical student is specifically referring to grade two haemorrhoids, thus relating the previous information that they have obtained about the simulated patient (that they have grade two haemorrhoids) to the explanation. Here the medical student is showing that they have understood previous information gained from before the consultation even began about the simulated patient, and are now expressing this understanding to them. This links with a point that the focus group was eager to make: that the empathetic process should begin before the consultation, with the doctor taking the time to go through the patient's notes before he or she initiates the meeting.

In addition to the medical student discussing previous symptoms of the simulated patient, it was also deemed empathetic when the same was done with previous treatments, for example, when talking about the simulated patient trying fibre gel: 'you're very right in in trying fibre gel' (005, line 146), and other conservative methods: 'so it sounds to me like you've tried some of those things already' (009, line 209). Therefore, it can be seen that through the medical student firstly obtaining relevant information about the simulated patient's symptoms and treatments, and then relaying this information back to the simulated patient, they are creating opportunities for empathetic expression.

9.4.2. Support and Future Treatment

The effect that obtaining and relating information has in the empathetic process can also be seen through the medical student's consideration of the social support the simulated patient has, and the future treatment the latter may undergo. For example, in two cases which were coded as empathetic, the student enquires about the duration of the haemorrhoids:

(137) [004]

210	Student:	yeah (.) it seems quite likely (0.5) um
→ 211		especially if you've uh (0.5) had it for a
212		little while
213	Patient:	while before that more than ten years (.)
214		probably
215	Student:	mhmm (.) okay

(138) [016]

95	Student:	[oh right okay (.) right okay
→ 96		(.) so you had this problem for the last
97		two decades
98	Patient:	pretty much yeah

This has the effect of showing the simulated patient that the medical student is taking the concerns seriously, as he or she attempts to comprehend not just the severity of the illness at that point in time, but also the severity of the illness in terms of the length of time the simulated patient has had to endure it. It is important that the student does not pass off the patient's lived experience of the illness, and he or she must ensure that this is acknowledged. Another example relates to this:

(139) [007]

95	Student:	if they do come back we can (.) do it
96		again (.) there are other procedures that
97		we can do (.) but they tend to be reserved
98		for once the haemorrhoids (0.5) um get a
99		bit worse um because they're=
100	Patient:	=what worse than ↑mine
→ 101	Student:	i-i know that sounds sound of >sort of< um
102	Patient:	yeah

In this example, the medical student is relating the treatment options to the simulated patient's personal condition. However, in the first example, the student reveals that the haemorrhoids could progress to a more serious level, to which the simulated patient reacts with a sense of shock. The student quickly rectifies this with a repair strategy, (Schegloff et al., 1977) 'i-i know that sounds sound of >sort of< um' on line 101, and this is acknowledged by the patient on line 102. The example highlights the issue of whether it is best to give the patient an overview of the severity, or to focus on the grade of haemorrhoids in order to pre-empt reactions such as this, and avoid a breakdown of empathy as a result of too much or irrelevant information being given to the patient.

Another lifestyle factor which was deemed empathetic involves the support network of the patient:

(140) [010]

265	Patient:	as i say my (0.5) partner's getting little
266		fed up of me moaning about it so
267	Student:	yeah
268	Patient:	um
→ 269	Student:	cos you mentioned that earlier
270	Patient:	well i think she thinks that i'm a bit too
271		much sort of (.) making too much fuss
272		really but (2.0) yeah she doesn't know
273		what it's like y'know

Surprisingly, this technique is not employed frequently throughout the data, and this is likely to be due to the medical student not initiating, or veering away from, discussion concerning the social support network of the simulated patient, reasons for which are discussed previously.

9.4.3. State then Relate

Perhaps the most efficient way for the medical student to convey the information required while at the same time making it relevant to the simulated patient was

through a sequence which involved the medical student first uttering a statement or statements about a disease, and then relating this information back to the simulated patient by asking if any of it was familiar to his or her situation. For example:

(141) [004]

143 Student: [right (.) okay and um obviously you that
144 it can cause pain (.) um and bleeding have
145 you had any bleeding

146 Patient: yup i-uh-i almost always get some bleeding
147 (.) not (0.5) in the toilet itself but um
148 (.) °°y'know in the°°

Moreover, in other cases, the simulated patient would provide a small interjection between the statement from the medical student, and the student then attempting to relate the information to the simulated patient (this technique shall be referred to as 'state then relate'):

(142) [001]

→ 116 Student: yeah (.) sometimes bleeding is associated
117 with haemorrhoids

118 Patient: definitely=

→ 119 Student: =i understand you've had some

120 Patient: yeah

(143) [010]

→ 151 Student: um and then (.) you would (.) want to see
152 your doctor about that (.) and if you were
153 feeling unwell (.) if you (.) er lost
154 weight (.) if your um bowel habits changed
155 (0.5) that would be something (.) to (.)
156 see your doctor about

157 Patient: right

→ 158 Student: so has any of ↑that happened you

159 Patient: um (.) in terms of

160 Student: weight loss:: or

161 Patient: no (.) not really i’ve always been fairly
162 ( )

In these examples, it can be seen that the student first initiates a statement of what symptoms would typically be associated with the ailment the patient is suffering from shown in example 142, line 116-117 and example 143, line 152-154. The patient then proceeds to provide some indication that they have registered this information (example 142, line 118; example 143, line 157. This is followed by the medical student then relating the symptoms typically associated back to the patient specifically, shown in example 142, line 119, and example 143, line 158. The use of this technique acts as a good check for other symptoms that the simulated patient may be experiencing, but is not associating with the ailment he or she has come to see the doctor about. For example, a patient may suffer from IBS, but not associate this with haemorrhoids if the correlation between them is not understood. Moreover, the technique also provides an element of reassurance to the patient; if they later develop symptoms associated with the disease, or do not wish to divulge other symptoms for whatever reason, then the doctor going through the potential associated symptoms provides peace of mind, hence it may be seen as a prelude to empathy, or ‘potential empathy’. However, the student must be cognisant of the fact that by stating a potential symptom, they may inadvertently direct the patient to list symptoms they do not have. Hence, the ‘state then relate’ technique should be used with caution. If the patient already has been given a diagnosis in a previous consultation (as is the case with this scenario), then the ‘state then relate’ method is an effective method to reassure the patient that the symptoms are not related to anything else (such as the patient’s concern about bowel cancer in this case), but it is less effective, and could even be detrimental, in eliciting symptoms required for a diagnosis.

A medical student’s ability to successfully gather information, retain it and then relay it back to the patient in context is a useful empathetic device, and one which

was coded by all participants. The elements discussed as empathetic devices from this section are summarised as follows:

- Retaining information about the patient's symptoms and treatment is vital to the expression of empathy, and this information can stem from previous consultations, earlier in the same consultation, or in the same interactional sequence in the consultation. It can also relate to the support and future treatment the patient will have.
- Making a statement or statements about an disease and then checking if any of these symptoms are associated with the patient's lived experience of the illness is a good technique for conveying a broad amount of information, but still centring the consultation around the patient's needs.

9.5. REASSURANCE STRATEGIES

Strategies involved in reassuring a patient were coded as a form of empathetic expression in the data. These consisted of the medical student stating that the way the patient was feeling was understandable, commenting on the severity, having a positive outlook and detailing future support.

9.5.1. Use of 'Understandable'

In this instance, the use of the word 'understandable' on the medical student's part was deemed to be empathetic in a number of instances throughout the data. The medical student is demonstrating understanding that the simulated patient wants to know that he or she is not the only person in the world with the illness; it is an attempt to make it easier for the simulated patient to deal with their condition if he or she knows that other people have been through the same circumstances and been okay. Examples are shown as follows:

(144) [001]

151 Student: okay is there anything else you'd like to
152 ask at the moment

153 Patient: just to make sure y'know jus to (1.0) sort
154 of deal with the problem really↑

→ 155 Student: okay (0.5) that's very understandable (.)
156 i'll arrange another time to see the
157 doctor at the hospital

(145) [006]

48 Patient: °°so yeah°° um i'm just (.) now it's just so
49 bad i just really want to get it sorted
50 out

→ 51 Student: yeah of course (.) i can understand that
52 (.) yeah (0.5) so yeah >so i mean< it's
53 already been it's already been going on
54 quite a long while (.) >you've been
55 through quite a lot already really
56 h[aven't you<

57 Patient: [well yeah (.) i mean the IBS is bad
58 enough n then for it (.) i mean hhhfff (.)
59 i don't know why °i thought° i suppose they
60 might be (0.5) connected uh (0.5) the two
61 things (.) sort of (.) haemorrhoids and
62 (.) and um (.)IBS

(146) [007]

339 Patient: and i-i-i was just hoping i could have
340 something done that would be per↑manent
341 really

→ 342 Student: well that's very understandable um (1.0)
343 the sort of (0.5) worry about

344 Patient: mmm

345 Student: other things (.) um (1.0) obviously the
346 doctors at the hospital are very
347 experienced and um (1.0) and um (1.0) you
348 know you can be sure that they've done
349 everything that they need to do (.) um
350 (0.5) and as i said (.) we may find that
351 one of these things (.) um like banding

(147) [010]

110 Student: but it's important to remember that
111 there's many <u>other</u> causes (.) for bleeding
112 (.) um some as in-in your case
113 haemorrhoids which is a very (.) uh benign
114 condition (.) meaning that >y'know< it
115 really is=

116 Patient: =doesn't feel that way °°but y'know°°

→ 117 Student: um (.) i-i understand this must be
118 difficult for you

119 Patient: yeah

120 Student: um (.) >but yeah< (.) i want you to be
121 reassured that (0.5) they've found out
122 what your problem is and (.) it is
123 treatable

124 Patient: do you think they'd have looked to see if
125 it was (.) cancer or not (.) or

(148) [011]

355 Patient: [yeah
356 well really my main (.) well what i'd
357 really like in a perfect world is to (.)
358 have something that makes them go away (.)
359 completely

→ 360 Student: that's yup that's understandable (.) yup

361 Patient: um i-i (1.5) surgery wouldn't be my first
362 choice (.) in all honesty=

363 Student: =okay

364 Patient: but having said that (0.5) if that was to
365 be the one that would <u>definitely</u> get rid
366 of them (.) i would consider that i think
367 (.) but °the° the other two (.) you
368 mentioned (.) you said that (.) they
369 should also (.) make them

(149) [012]

96 Patient: that's what i want to do yeah i want it to
97 get them (.) sorted out

→ 98 Student: absolutely i can understand that

99 Patient: yeah

(150) [015]

56 Patient: um at the time he (.) he suggested that he
57 thought it was probably

58 Student: mm

59 Patient: haemorrhoids

60 Student: right

61 Patient: and um (.) but he thought that i needed to
62 sort of get it checked

→ 63 Student: of course (.) of course (1.0) your
64 concerns about bleeding is completely
65 understandable (.) mm you're sitting a bit
66 um (.) are you comfortable enough

67 Patient: well i-like i'm alright i'm just (.)

68 sor[e (.) to be honest

69 Student: [sure (1.0) yup (.) <okay> (.) okay umm
70 (0.5) apart from having this problem with
71 your back passage do you have any other
72 past medical history

73 Patient: um (.) i think i've got some IBS

While this demonstrates the medical student attempting to reassure the simulated patient about the illness, it must be considered how felicitous these statements are. It must be remembered that the medical students have exams based on their consultation skills training, and from ethnographic observations made by the researcher, a culture appears to have developed amongst them believing that by

uttering 'that's understandable' they will gain marks for empathetic content. It appears that many medical students see the uttering of 'that's understandable' as a core component in the RAV model used to express empathy, which the current assessment at UEA is based upon. In other words, 'that's understandable' refers to the acknowledging of the patient. In examples 147 and 149 role-player specifically coded the acts as being empathetic; however, it can be seen from the sequential turns following these utterances involving the phrase 'understandable' that the simulated patient still does not seem to be completely reassured. In 145, there is continuing talk about negative symptoms: `i suppose they might be (0.5) connected uh (0.5) the two things (.) sort of (.) haemorrhoids and (.) and um (.)IBS`, and in 147 the patient asks directly about the possibility of cancer, following from earlier in the consultation. Hence, while the use of the word 'understandable' may be deemed empathetic within the medical educational environment (all participants coded at least one use of 'understandable' as being empathetic), the actual positive effect it can have on the consultation may be questionable. The realisation of this word is a good way of reassuring the patient that their thoughts and feelings are expected, but as shown in example 147, it requires further exploration and reassurance. Moreover, if the medical student says they understand, but the act is uttered infelicitously, then Grice would argue that it actually serves as a flouting of the manner and quality maxim (Grice, 1975: 78-79). This is shown best in example 150, where the student says the concerns about the bleeding are understandable on lines 63-65, but then rather than dealing with this concern directly, they proceed to focus on physical symptoms on line 65 (where they enquire about comfort), and lines 71-72 (where they ask about the past medical history). All of this leaves the patient's true agenda unexplored (namely that they want to be reassured about cancer), and thus it could be argued that the use of 'understandable' here has actually been used infelicitously and halted the patient at a vital point of the consultation, hence the phrase must be used with caution.

9.5.2. Severity of Ailment

Extenuating the severity of the ailment is another common strategy deemed to act as an empathetic expression, particularly in relation to the simulated patient's concerns

about bowel cancer in this scenario. The medical student is keen to convey that the tests indicate the symptoms are caused by nothing more serious than haemorrhoids:

(151) [002]

189 Student: right (.) you're worried that it could be
190 something (.)[more serious
191 Patient: [worse
→ 192 Student: well um (.) just to reassure you that um
193 haemorrhoids is the last diagnosis (.) it
194 wouldn't um they wouldn't diagnose it
195 unless they'd excluded all the other
196 [possibilities
197 Patient: [okay (.) right

(152) [003]

335 Patient: [um (.) i suppose
336 that that er as i've been to the hospital
337 and i've seen the consultant and he said
338 that he thinks it is haem-haemorrhoids
339 that that that is you know that that's
340 what we're sort of talking about really
341 and that that was it
342 Student: yeah
343 Patient: sort of thing
344 Student: y-y-yes yeah so (.) it is it is diagnosed
→ 345 as haemorrhoids nothing more serious °>than
346 that<° which is [which is good news
347 Patient: [yeah (.) yeah

(153) [005]

238 Student: okay (.) and um have you had the results
239 back

240 Patient: yeah yeah i'm gona just said (.) just say
241 it's grade two haemorrhoids

→ 242 Student: yeah well it's unlikely to be anything (.)
243 more sinister (.) um (0.5) they've
244 investigated and (.) and you're fit and
245 well in yourself aren't you

Since the issue of bowel cancer is one of the simulated patient's primary concerns in this case, for the medical student to not address this would be considered by Grice as a flouting or even violation of the relevance maxim (Grice, 1975: 78-79). However, the student must also be careful not to give the answer definitively, due to the false negatives which may occasionally be returned with these results (hence the student does not say it is not cancer when it might be). This is not done in the first two examples; however, in example 153, the use of the term 'unlikely' brings in an element of probability. Thus while the medical student is expressing to the simulated patient that it is unlikely to be cancer, they are not ruling it out and thus making themselves susceptible to a malpractice lawsuit, but at the same time they are showing empathy with the attempt to reassure the patient. In addition to referring to the severity of the illness, at times, the medical students used the word 'reassure' directly in the conversation:

(154) [006]

238 Patient: yeah (.) and i mean i (.) I S'POSE i am
239 quite worried about >sort of< bleeding
240 from down there

241 Student: yeah of course (.) yeah

242 Patient: i mean it could be anything °couldn't it°

→ 243 Student: yes it can but hopefully yeah i can talk a
244 bit more about bleeding as well and
245 hopefully reassure you about that

(155) [010]

→ 120 Student: um (.) >but yeah< (.) i want you to be
121 reassured that (0.5) they've found out
122 what your problem is and (.) it is
123 treatable

124 Patient: do you think they'd have looked to see if
125 it was (.) cancer or not (.) or

126 Student: well with the sigmoidoscopy they would
127 have been able (.) to check your um (1.0)
128 the lower part of your colon

In contrast to addressing the issue of reassurance directly, the medical student also attempts to reassure by shifting the focus of the consultation onto the scientific side. For example:

(156) [010]

136 Student: right okay (.) and can you describe what
137 the blood was like

138 Patient: it was red

→ 139 Student: °°it was red (.) okay°° well um (.) often
140 they say that when the blood is more fresh
141 er red-dy colour (.) that's likely to be
142 something from around the area (.) like
143 haemorrhoids (.) or perhaps (.) if the
144 blood was darker (.) or mixed in with the
145 stool itself (.) that would indicate a
146 bleeding higher ↑up

(157) [012]

379 Student: i'm sure that's quite scary

380 Patient: well yeah

381 Student: has that been playing

382 Patient: i mean it's at the back of my mind yeah

383 Student: okay um well because you've been examined
→ 384 they will have looked for that (.) cos
385 that is one of the differentials (.) one
386 of the causes

Although in the above cases the utterances were coded as empathetic, this strategy can detract from the patient-centeredness of the consultation. For example, if a patient tells the doctor they have been suffering from anxiety, the doctor may focus on the physical side-effects such as nausea or insomnia, rather than the psychological cause for the anxiety. Hence reassurance can be offered to the simulated patient through the medical student commenting on the severity of the ailment (but retaining the probability that the comment may be inaccurate), directly reassuring the simulated patient, and if indirectly reassuring, then relating it to the simulated patient's psychological needs, as well as physical needs.

9.5.3. Positive Outlook and Future Support

The medical student providing the simulated patient with a positive outlook and future support for his or her condition was another mechanism which was perceived to be associated with empathetic expressions. A positive outlook was achieved through the student commenting on how the deterioration of the symptom could be halted or slowed:

(158) [007]

182 Student: just to help the stools be more formed so
183 you don't have to strain as much

184 Patient: yeah

185 Student: but as you say (0.5) um (1.5) the damage
186 has already been done we don't (.) but (.)
→ 187 again (.) we can't °like° (.) we can stop
188 them from getting worse ( )

(159) [009]

136 Student: and you're a grade two

137 Patient: >okay< does that mean i'm going to get
138 worse then

→ 139 Student: ummm it has the potential to get worse but
140 hopefully with the treatments we'll talk
141 about later [that won't necessarily happen

142 Patient: [okay (.) yeah

Furthermore, in some cases, the medical student would play down the pain involved in treating the symptoms:

(160) [008]

318 Student: um (.) but what (.) what sounds

319 Patient: i don't (.) i-i can't really tell because
320 i suppose >you know< (.) th-they all sound
321 a bit painful if (.) um i mean uh you kind
322 of think maybe the injection would just
323 actually make them (.) go away if that
324 wasn't painful maybe that would be the
325 least uh

→ 326 Student: i think (.) i don't think banding or the
327 injections are actually ↓painful (0.5) um
328 you shouldn't be able to feel that at all

(161) [011]

318 Student: um (.) and then there is um (.) some more
319 sort of more kind of (.) permanent
320 treating

321 Patient: mmm

322 Student: sort of things we can look at (.) um (0.5)
323 they can inject (0.5) into the haemorrhoid
→ 324 (.) which sounds painful [but (.) it
325 shouldn't ↑be

326 Patient: [↑mmm

In both cases, the medical student is showing their understanding that the simulated patient may be concerned about the treatment and/or progression of the illness, thus acting as a method of reassurance. As well as this, the medical student also looked for positives in the simulated patient's condition:

(162) [003]

291	Student:	hmm yeah yeah (.)and um would ↓you err
292		like more information on ↑sort of (.) more
293		um invasive surgery at the moment
294	Patient:	well if there is anything i might as well
295	Student:	okay well well if that doesn't work and as
→ 296		i say it works in the vast majority of
297		patients

(163) [005]

291	Patient:	↓no (.) maybe i'll just have to figure out
292		some way of standing up more though
→ 293	Student:	well you're qui-you're quite lucky in that
294		you work at home n n you can [keep your
295		hours more flexible
296	Patient:	[sure hmm (.)
297		okay (.) okay

Both the above examples offer the simulated patient reassurance by looking at the situation optimistically. In example 162, the medical student is offering reassurance to the simulated patient based on previous success rates, whereas example 163 provides optimism based on how the disease impacts upon the simulated patient's lifestyle. Finishing the consultation in a similar fashion by ending on a positive note was the final reassurance strategy identified, where relevant information was passed on to the respective parties (example 164), and an offer for the simulated patient to return should they feel the need (example 165), were made:

(164) [001]

→ 167 Student: _____ mmk i (.) i will ss-certainly flag
168 up your concerns with the doctor (.) and
169 um (.) um i think i-it's reasonable (.) to
170 assume that you'd like this treated [as
171 soon as possible

172 Patient: [yeah
173 (.) yeah

(165) [012]

396 Student: um we've gone through a lot today (.) and
→ 397 it is a lot to take on (.) if you've got
398 any other worries don't hesitate to come
399 back and have a chat with us

400 Patient: oh right

The following reassurance strategies have been explored above in relation to perceived expressions of empathy:

- Acknowledging the patient's concerns with derivatives of the word 'understand'.
- Reassuring about severity if the patient is concerned, but making sure the statement is not stated as an absolute.
- When reassuring indirectly, making sure it is based upon the patient's wants and needs.
- A positive outlook and future support is preferable at the end of a consultation (although not always possible).

9.6. PROFESSIONAL PERSPECTIVE

The medical student giving his or her personal perspective on an aspect of the simulated patient's lived experience of the illness was coded as an empathetic strategy. The use of this strategy occurred predominantly in the form of declaratives,

and acted as a method for the medical student to concur with the simulated patient's viewpoint, thus enhancing the simulated patient's face. These strategies occurred in three main strands: the use of expert opinion, the verbalisation of the medical student's thoughts on the simulated patient's emotions, and the verbalisation of thoughts on the simulated patient's lifestyle.

9.6.1. Expert Opinion

The doctor giving an expert opinion is a common interactional occurrence in medical consultations. Since the data used in this project utilised simulated consultations involving medical students who are not supposed to give information, the prevalence of expert opinion was infrequent. However, there were still sections of the consultation where what could be considered an 'expert opinion' was expressed. For example:

(166) [009]

175 Patient: so (.) d-you think i've got it (.)
176 basically from (.) having constipation and
→ 177 Student: that seems most likely (.) to me
178 Patient: °>alright<° and that would give it to you
179 because it's (.) too hard to push the
180 Student: yeah

Here, the medical student is agreeing with the simulated patient's opinion through a statement relating to the probability of the simulated patient being correct, and Grice would consider this as relating to the quality maxim (Grice, 1975: 78-79). Through this utterance, the medical student is implying that the simulated patient is not flouting the quality maxim (they are being honest with the patient about their view on the ailment), thus indicating that the medical student is reassuring the simulated patient that the opinion is valid and hence being empathetic. In another example, the medical student offers the simulated patient reassurance about the condition:

(167) [007]

175 Student: just to help the stools be more formed so
176 you don't have to strain as much

177 Patient: yeah

178 Student: but as you say (0.5) um (1.5) the damage
179 has already been done we don't (.) but (.)
→ 180 again (.) we can't °like° (.) we can stop
181 them from getting worse ( )

182 Patient: yeah

Similarly to the previous example, here the doctor utilises a declarative sentence structure to demonstrate an expert opinion. They are using their own medical knowledge surrounding the possibilities and limitations of medical science to reassure the simulated patient about the progression of the illness. Also, the use of 'we' in this case seems to relate to the medical student and other medical professionals (the medical team looking after the patient) doing their best and work together to help the patient. Thus it can be seen that the use of expert opinion can reassure the simulated patient both in terms of the medical aspects, and interactional aspects in the consultation, although further examples of this in authentic consultations would be advantageous.

9.6.2. Opinion on Emotions

The information sheet (**FORM 3A**) given to the role-players indicated that the scenario involved the simulated patient feeling an array of emotions. Most prominently, these involved the pain the haemorrhoids were causing, the worries and concerns that the symptoms may be related to something else, and the embarrassment associated with the disease. One of the ways the doctor acknowledged the simulated patient's emotional state was to align themselves with the actual emotion the patient was experiencing:

(168) [003]

60 Patient: it's (.) it's (.) just excruciating
61 actually

62 Student: is it °is it°

63 Patient: it <u>r</u>eally <u>r</u>eally is so i'm hoping that we
64 can (1.0) get something sorted out

→ 65 Student: okay (.) well °sure sure° it must be
66 painful[

This utterance is implicated by the prior utterances, and demonstrates a preference for agreement by the medical student, where they proceed to align themselves with the patient's emotional state (namely that they are in pain in this example). In addition to this, the doctor may also refer to the theoretical pain caused by the illness:

(169) [011]

156 Student: it's just a vein with lots of blood in it

157 Patient: oh really

→ 158 Student: and um (.) i <u>know</u> that they're very
159 painful

160 Patient: mmm

Here, the use of the first person singular makes the utterance more subjective, and hence more believable. It is more likely that the simulated patient would feel empathised with here, as the statement implies that medical student may have been through it before, even if this is not the case. The first person was also used to state the medical student's opinions on the observed pain:

(170) [002]

145 Patient: because the last six months they've been
146 (.) excruciating

→ 147 Student: ss i can see you're quite uncomfortable at
148 the moment

149 Patient: yeap

Building on the subjectivity in the previous example, this utterance takes the interaction one step further, as it is incorporating empirical evidence into the doctor's opinion: that he or she has observed that the simulated patient is uncomfortable, and that this has been associated with the haemorrhoids being painful. In addition to the first person, the use of the second person is also utilised to ask indirectly about pain:

(171) [008]

300 Patient: [well i'm-
301 i'm keen to get them sorted out (.) ummm
302 suppose i'm almost thinking what would be
303 the least painful (.) treatment to have
304 (.) but you know um (.) perhaps if i was
305 to (0.5) to take the fibre gel again (.)
306 sort of thing (.) that would help

→ 307 Student: i mean you sound like you're in quite a
308 lot of pain um (0.5) so (.) maybe go um
309 (.) one of these options to get rid of the
310 ones you've already got (.) um as well as
311 using the other (.) >sort of< conservative
312 (.) methods and drinking lots of water and
313 the fibre gel

(172) [001]

300 Student: okay (.) that's (.) i'm glad you've
→ 301 understood (.) you're obviously in pain
302 >in terms of pain< are you taking any pain
303 killers at the ↑mo↓ment

This utterance is based on empirical observation of the simulated patient's discomfort. However, it is more likely to invite a response from the simulated patient due to the use of the second person pronoun. By using 'you', instead of 'I', the focus of the utterance is shifted from the medical student to the simulated patient, and this

has the effect of directly bringing the simulated patient into the consultation, which could arguably be seen as a more empathetic method of expression.

The use of the first person is also apparent when the medical student states opinions on the worries and concerns that the simulated patient may have:

(173) [012]

64 Patient: yeah well (.) thanks i mean i (.) i
65 realised that (.) hff things had got a bit
66 worse i mean (.) especially about six
67 months ago (0.5) ummm i-it just became
68 very painful down there (.) very painful
69 (.) and and i just started to get (.)
70 bright blood on >on the toilet paper< as
71 well

→ 72 Student: i imagine that was probably quite scary

73 Patient: fff it was yeah (0.5) didn't know what was
74 going on really

Similarly to the use of the first person with the imagining of pain, here it is used to express theoretically what concerns the simulated patient may have. Hence this links to the medical student projecting him or herself into a cognitive model of how the disease impacts the simulated patient, and then expressing this process to the simulated patient, thus demonstrating empathy. The second person is also used to convey this, and again this has the effect of shifting the focus of the consultation back to the simulated patient:

(174) [006]

192 Patient: =so you're sure it isn't anything else
193 °°more serious°°

194 Student: no no °no° that's why >so with-with the<
195 scope they will've (.) um >y'know< if they
196 didn't explain this to you at the time
197 (0.5) they look sort of right round the
→ 198 back (.) because of course i mean you can

199 imagine you perhaps might be concerned
200 that it could be <cancer> or something
201 like that

202 Patient: yeah well my (.) my dad (.) had bleeding
203 from his back passage

204 Student: oh i see

205 Patient: and it turned out to be bowel cancer (.)
206 and (1.0) er he had a whole kinda um
207 y'know (.) colonoscopy n (.) he died
208 °another° eighteen months later

One final regarding the patient's concerns relates back to the idea of alignment discussed previously, where the student's utterance is preceded by the patient making a similar point:

(175) [003]

237 Student: that's the common out-outpatient procedure
238 that we can do (.) um as an outpatient
239 (0.5) um (.) if things progress <if that
240 doesn't work> there are other (.) other
241 urm (.) other procedures so we can do
242 something called ssst ah well it's
243 basically an in-injection of um a chemical
244 which does the same thing >basically cuts
245 off the blood supply<

246 Patient: WHAT in°to°

247 Student: into the into[the haemorrhoid yeah

248 Patient: [huuuu

249 Student: um

250 Patient: that sounds terrible

→ 251 Student: it does sound terrible actually doesn't it
252 but it's not IT'S NOT supposed to be
253 painful (.) but it is less successful than
254 a band ligation

Statements associated with embarrassment were more generalised:

(176) [006]

237 Student: [yeah (1.0) so uh (.) what do you
238 understand about haemorrhoids >have they
239 explained anything to you alre↑ady< (.)
240 about what they actually are↑

241 Patient: °they said it's° (.) something to do with
242 um (.) sort of st↓raining when using the
243 toilet and things (1.5) um (.) i think i
244 mean YA KNOW i-it is quite bad (.)
245 sometimes (.) it seems to sort of (.)
246 project out y'know (.) °the back passage°
247 and uh (.) yeah (.) it's very painful

→ 248 Student: of course it all sounds very unpleasant
249 (0.5) particularly with the IBS as well
250 (.) so um (.) >so what are the main< sort
251 of things that you would like to know a
252 bit more about to↑day

(177) [009]

237 Patient: as well (.) whatssit just seems what i
238 always have to do that y'know (.) i always
239 sit on a (0.5) >sort of< circular cushion
240 and °yes it's° (.) so painful and er

→ 241 Student: it's pretty rotten isn't it

242 Patient: yeah yeah (.) it seems a bit (0.5) er
243 unfair

In contrast to the perspectives on pain and concerns, when discussing embarrassment, pronouns were not used to relate the disease back to the patient.

For example, in example 171, the student says 'you sound like you're in quite a lot of pain um' and in example 172, they say 'you're obviously in pain', referencing the pain directly to the patient. However, in

the above examples 176 and 177, the student does not specifically relate the disease to the patient, but talks about the symptoms in more general terms ('pretty rotten', sounds unpleasant'). It could be argued that this is due to the taboo nature of what is being discussed. Through the evasion of pronouns, the medical student is avoiding attaching either him or herself, or the simulated patient to the embarrassing nature of the disease, and this helps maintain both parties' face. Therefore, it can be seen that the use of the first and second person is central to the perception of empathetic expression, and through the careful use of these pronouns, a medical student can appear to express empathy with regard to the simulated patient's emotions.

9.6.3. Opinion on Lifestyle

The medical student's opinions about the simulated patient's lifestyle were also coded as empathetic in a number of instances. Like the medical student's opinion on emotions, the first person was also utilised to share the student's opinion (note that in these examples, the context involves the medical student discussing how the ailment is affecting the day-to-day lifestyle of the simulated patient):

(178) [011]

109	Patient:	=well it is because you can't (1.0) you
110		can't really concentrate on what you're
111		doing at work because really all you're
112		ever thinking about is [the pain that
113		you're in
114	Student:	[no
115	Patient:	you know
→ 116	Student:	i can understand why you'd really want to
117		(.) get it >sort of< sorted=
118	Patient:	=i really do yeah

(179) [005]

65	Patient:	quite demoralising you know

→ 66 Student: yeah i can i can see that you you don't
67 seem very (0.5) you seem kind of (.) fed
68 ↑up with it ↓all

69 Patient: well yeah i mean if i could just get it
70 sorted out once and for all that would be
71 (.) such a relief you know i'm just

In both these cases, the medical student is expressing an opinion based upon what he or she believes the simulated patient has been experiencing. This is also true of other examples relating to opinions on lifestyle:

(180) [009]

268 Patient: uuummm (.) but i am (.) y'know just wana
269 get (.) rid of them right now i could just
270 get rid of them and move on that would be
271 fantastic

→ 272 Student: it sounds to me like you just want to (.)
273 put all this behind you

274 Patient: oh definitely (.) kind of a phrase

(181) [004]

374 Patient: i think that probably it (.) even with
375 surgery you know i'm a bit (0.5) about
376 surgery but i think if i thought they were
377 going to get rid of them (.) then i (.)
378 i'd be more inclined to do that

→ 379 Student: it does sound like a good idea because
380 they're obviously impacting on your life

381 Patient: yeah

In these examples, the use of the word 'sound' gives the simulated patient the opportunity to expand upon or oppose the medical student's opinion. It permits the student to express an opinion, while at the same time leaving the utterance open to expansion or opposition from the simulated patient.

To summarise, professional perspectives can be shared with the patient as a way of expressing empathy in the following ways:

- Expert opinion can reassure the patient both in terms of the medical and psychological aspects of the consultation.
- The careful use of pronouns can aid in the medical student's expression of opinions surrounding the patient's emotions. However, avoidance of pronouns is sometimes preferable for both parties.
- Use of the word 'sound(s)' can be used to express an opinion, while leaving the opinion open to opposition or expansion from the patient.

SECTION FOUR

CHAPTER TEN: DISCUSSION

10.0. INTRODUCTION

This chapter reflects on the principle findings from this research, and then proceeds to appraise the methodological approach taken in collecting and analysing the data, with a focus on the approach, quality of data and choice of participants. The limitations of the research are then raised, and finally, the findings are compared with the results from previous related work in the field.

10.1. PRINCIPLE FINDINGS

Rather than existing at one or two moments, empathy was coded as being present at various points throughout the consultation in various forms. The instances which were coded seemed to build toward empathy as an integrative practice, where it was possible to express the concept in numerous ways, but which all contributed to the overall empathetic ethos of the consultation. The findings from the focus group supported this. Whereas the focus of the researcher, medical students and simulated patients was predominantly concerned with empathy on an interactional level, the focus group developed the idea of empathetic rapport being integrated at a much earlier point than the consultation – as far back as the administrative aspect of the process. In addition to this, the focus group also raised issues which were not apparent from the interactional analysis of the consultations, such as the level of formality a doctor should use when consulting with a patient, the patient's familiarity with the consultation process, and the time limits imposed upon the consultation. The amalgamation of findings from both the simulated consultations and focus group was very much a positive in this project, as it meant that a more holistic view of empathy was explored as a product of these methods.

The focus group also raised the issue of non-verbal behaviour and gesture being important in the consultation (as did many of my colleagues, friends and family),

although the coding in each of the consultations had far more emphasis and detail in relation to the verbal aspects of communication. Eye contact, nodding, smiling and laughing were elements of the interaction which were coded as empathetic by the parties involved, and these seem to relate to the idea of mirroring or copying the patient's actions to an extent; however, when compared to the level of detail provided in the coding of verbal empathy, these seemed deficient in detail considering the supposed importance given to them. Hence, it may be assumed that either gesture and non-verbal behaviour does not play such a large role in the expression of empathy, or that the coding of the linguistic aspect of the consultation takes preference over the non-linguistic, and that future research must develop a method of encouraging any coders to focus on the non-linguistic, as well as linguistic, features.

The initial stage of the interactional analysis built toward an inductive framework pertaining to how empathy was perceived to be expressed in undergraduate medical education. Within this framework, two prominent themes arose, which each contained multiple sub-categories relating to empathetic interaction. These were what the medical student must consider about the patient's personal experiences of an illness, and what the student can do in interaction to create or enhance the chance for empathetic expression. The following were coded as empathetic in the data, and were related to eliciting patient experiences:

- Patient feelings:
    - Verbalising opinions on the patient's thought processes.
    - Considering the patient's lived illness experience and how it may have differed from others' experiences.
    - Considering both the patient's surface and underlying concerns, and not being afraid to make these explicit.
    - Using euphemisms when discussing taboo or distasteful topics.

- Patient knowledge:
    - Checking the patient's starting point.

- Checking the patient's desire for knowledge in relation to the disease and the treatment options.
- Avoiding the use of jargon and praising the patient's knowledge.

- Comfort:
  - Considering the patient's immediate and continuing comfort.
  - Recognising and allowing for the patient to stop the consultation should they be in extreme discomfort.

- Lifestyle:
  - Linking the disease to the patient's lifestyle.
  - Considering the impact of the disease on both the patient's occupation and personal life.

In addition to these, the following were also coded as empathetic in the data, and were related to initiating empathetic opportunities:

- Rapport:
  - Making offers to the patient, praising the patient, taking a genuine interest in what the patient had to say, and agreeing with the patient's views all enhanced their positive face.
  - Threats to negative face were mitigated when making suggestions, and through using 'I'm sorry to hear that', and making positive proclamations.

- Agenda setting:
  - Negotiating the agenda with the patient.
  - Allowing the patient to interrupt and contribute to the agenda.
  - Ensuring that the patient's agenda had been covered, and considering the patient's future actions.

- Checking understanding:

    - Ensuring that the medical student has understood the patient, and that the patient had understood the medical student.
    - Checking the right amount and type of information had been given.
    - Checking the patient's starting point, and not deviating away from exploring the patient's feelings further.

- Information retention and attachment of condition:
    - Retaining information about the patient's condition and then incorporating this into the consultation.
    - Making statements about the disease, and checking if these had been experienced by the patient.

- Reassurance:
    - Expressing understanding of patient's lived experience of illness.
    - Reassuring the patient about the severity of the illness.
    - Finishing the consultation with a positive outlook where possible.

- Professional perspective:
    - Using expert opinion to reassure patients about both the psychological and medical aspects of the illness.

Figure 1Figure 6 incorporates the above findings into an interactional paradigm pertaining to how empathy was perceived to be expressed in the research.

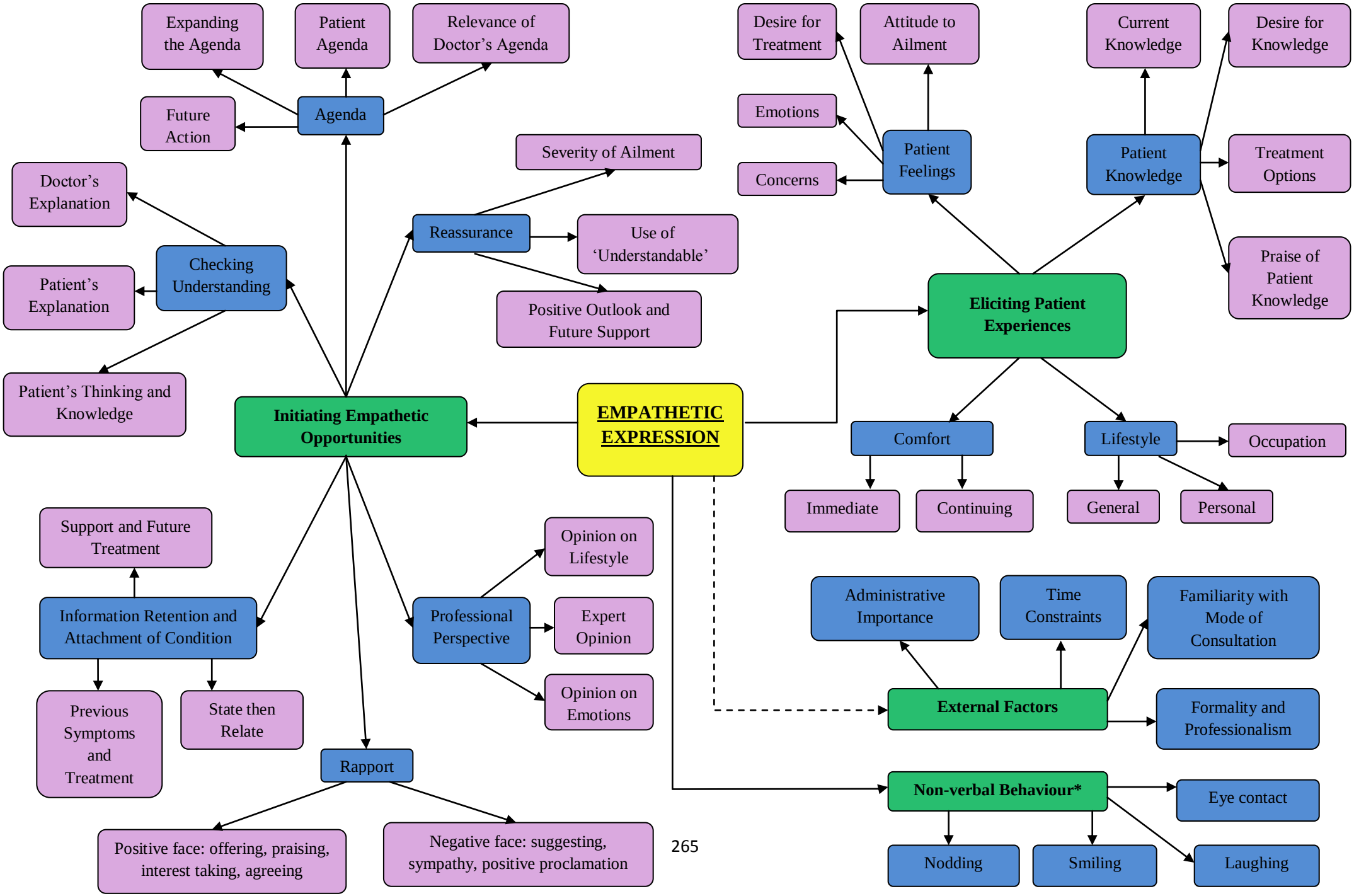

Figure 6. Interactional paradigm displaying categories derived from the data, and the subsequent explication of these categories.

10.2. APPRAISAL OF METHODS

10.2.1. Approach

The use of qualitative methods seemed well suited to the task of exploring perceived empathetic expressions. As has been argued previously, quantitative methods can provide invaluable information about levels of empathy and changes in empathetic attitude, but do not allow for in-depth analysis of the interactional features in the same way that the qualitative approach taken here does. The process of putting the medical student in the consultation, and then asking them to reflect on their actions gave unique, first-hand experience of their perceptions of empathy, rather than their idealised view on the concept which may have been revealed through a more phenomenological approach, and this was a strength of the research method.

The study's inductive approach allowed for the avoidance of predetermined definitions, which may have influenced the participant's perceptions of what an empathetic act involved. In a sense, the definition of empathy developed from the data, through the overlap and triangulation of the participants' coding. A major advantage of the coding methods used was that they allowed for large amounts of data to be coded very quickly, due to the number of participants coding each consultation. This could potentially be transferred to future research which requires coding on a larger scale. Another benefit of the two part methodological approach, involving quasi-grounded theory and sociolinguistic analysis, was that it helped to draw out the integrative aspect of empathy within the communicative paradigm. However, in a few instances, the data were coded by the simulated patients where neither the medical student, nor the researcher deemed empathy to be present. These appeared to be in relation to general politeness principles, although further work (deemed to be beyond the remit of this thesis) would help clarify the motivations for this coding pattern.

The explication of the analysis initially proved difficult due to the inductive nature of the first phase of the method. The utilisation of Grice's cooperative principle, and Brown and Levinson's politeness theory proved to be useful tools in the analysis,

particularly with regard to examining the initiation of empathetic opportunities. However, there were additional tools related to aspects of sociolinguistics such as the use of euphemisms, connotations and pronoun usage which also proved valuable in the explication of the analysis.

10.2.2. Quality of Data

The choice of simulated consultations as a method of collecting data paralleled the approach taken in consultation skills training at the UEA. However, it must be remembered that these are not authentic consultations, and so while results drawn from them are applicable to medical education, they may not be holistically transferrable to clinical practice. However, as far as the primary research question is concerned, the choice of simulated consultations was a practical method to examine perceptions of empathetic expression. Even if the coding were not what would otherwise be deemed 'genuine' empathy, it still provides information on what people believe empathy is, and how it is constructed and communicated in an interactional framework, thus giving a broader idea of what should be focused on in medical education.

The choice of the haemorrhoids scenario proved adequate for the aims of the project. This was, in part, due to the initial ambiguity in the scenario surrounding exactly why, where and when empathy should be expressed. It meant that the medical student had to delve deeper into the simulated patient's thought process and prise out what their underlying concerns were, as opposed to their surface concerns. The choice of a scenario more obviously associated with requiring empathetic expression, such as consulting with patient who had cancer, would not have had this effect. One of the limiting factors regarding the choice of materials was that only one scenario was used in the project. Admittedly, this scenario was acted out in two distinct ways by each of the simulated patients. However, it still must be considered that by only using one scenario, other potential emotions associated with empathetic expression – such as depression, anxiety and bereavement – may have been overlooked.

Coding of the data proved successful, with considerable overlap and agreement amongst the three parties. Contamination of the data was mitigated by making the simulated patient leave the room while the medical student was coding their data, and vice versa. One problem which this caused was that it took more time to complete, and therefore this could have affected the students' willingness not to rush their coding. It was assumed that since the simulated patients were being paid for their participation, time was not an issue when they were coding. The presence of cameras did not seem to have an impact on either the simulated patients (who were most likely used to this) or the medical students. By the fourth year of medical school, the students are used to being observed conducting simulated consultations, both in their consultation skills training sessions and their OSCE examinations, and this could account for why they were not intimidated by the recording of the session. Despite this, a decision was made not to incorporate permission to make the video data available to the public in the student consent forms (other than in conferences and for educational purposes) as it is doubtful that many medical students would have volunteered if this had been the case.

One of the aspects of coding which was less successful was in relation to gesticular and non-verbal empathetic acts. Those sections of the data which were coded with regard to this were generally to do with macro empathy: generic techniques used throughout the consultation such as smiling and mirroring the simulated patient's body language. The coding of verbal empathetic expressions was much more frequent, and this could be due to the approach taken in the methodology. A suggestion for increasing the coding of these acts in future research would be for the sound or tone to be removed from the data before showing it to the participants, thus inclining the participants to focus on the non-verbal aspects of the consultation. However, due to the time constraints and difficulties regarding the medical students' timetabling, this would not have been possible in this specific project.

10.2.3. Choice of Participants

The sample of fourth year medical students was suited to the aims of this research. The students were familiar with both the content of the scenario (haemorrhoids) and

the consultation skills required to conduct this type of consultation (gathering information, giving information and shared decision-making). Fifth year students would also have been suited, but were not approached as it was assumed they would be too preoccupied with final examinations. It may also have been appropriate to recruit third year medical students once they had received their three consultation skills training sessions for the year; however, this was not necessary, as theoretical saturation occurred during the recruitment of fourth years.

Ideally, the sample strategy would have taken a random sample from the fourth year medical students, but due to the nature of the study and the emphasis on participants taking part on a voluntary basis, this was not feasible. It was decided from an early stage in the planning of the project that students would not be offered money as a form of reward or compensation for their time, as this may have influenced the willingness of certain medical students to take part, and also may have been deemed unethical. Monetary incentives may have swayed those who were less altruistic to participate, and thus may have skewed the coding of empathetic expressions. It was felt that the offer of feedback and a copy of their consultation was a much more appropriate form of compensation, as well as another chance to practise their consultation skills. The motivation for the medical students' participation varied in a well-spread manner. Initially, students 001, 002, 003, 005 and 006 forthrightly volunteered their participation in the project from the outset, whereas students 004, 007, 008, 009, 010, 011, 015 and 016 volunteered in preparation for OSCEs. Students 012, 013 and 014 took part after their OSCEs to assist with the research project. Hence 8 students participated due to an interest in the project/to assist in the research, and 8 did it to aid with their OSCE preparation.

The role that PPIRes played in the validation of the framework further enforced the trustworthiness of the conclusions in relation to the theoretical saturation of the data. None of the members of PPIRes coded any aspect of the consultations viewed as being empathetic which did not fit into the pre-constructed framework derived from the thematic analysis. However, due to time restraints, the panel were only shown two of the 16 consultations, hence some features of empathetic expressions may not have been apparent in the selected videos. Moreover, it is unclear the level to which

the members of PPIRes were able to assume the role of a typical patient. Baseline data were not collected from each participant, but from speaking to them casually before and after the focus group, there was a distinct impression that at least some of the members had been involved in healthcare provision of some description. Hence, this could have affected their perceptions concerning the concept of empathy.

The participants in the group were all retired/semi-retired, and as such were not representative of a broad demographic. Since consultation skills training is a relatively new initiative in medical education, it could be argued that the members' expectations of a doctor's communication skills were lower than a younger demographic. However, judging by the content of what the focus group discussed, this did not seem to be the case, as all members were adamant that a doctor should have adept communicative skills, as well as proficient medical knowledge. In retrospect, the trustworthiness of the conclusions may have been increased through the recruitment of a focus group consisting of members chosen through a purposive sample strategy, with a more representative sample of the population. However, by the time this was realised, data had already been collected from the medical students, and the consent forms did not permit the use of the data in this way, hence it was not an ethically viable option, but could be incorporated into future research.

The two role-players employed on the project worked effectively, with their perspectives overlapping with one another, and with the medical students and researcher. Both role-players were highly recommended by a number of the tutors employed as part of the consultation skills team, and were suggested due to their vast amount of experience in simulated consultations (a total of 15 years between them). Importantly, the role-players knew each other well, and had worked together in the past in triadic consultations. There is the issue of the simulated patients being closely aligned with the teaching of the medical students, which might have skewed the findings. However, it also meant that the results were a more accurate reflection of empathy in medical education (not practice), which was the main aim of this project. The aim was to explore different perceptions of empathy from different viewpoints, and the simulated patients most certainly gave a distinct and unique perspective on the data. Also, the fact that they were different genders further enhanced the scope of the study. It must be considered that since they knew each other well, there may have

been overlap between them on their ideas of what empathy constituted, and their previous work could also have contributed to shaping their opinion of the concept. This was mitigated to an extent by the triangulation of perspectives with the medical students and researcher, although it still may have played some role in the coding process – particularly in the negative cases where neither the researcher nor medical student coded certain acts as being empathetic.

10.3. COMPARISON WITH PREVIOUS WORK

The conclusions drawn from this study complement the existing knowledge on the topic. The findings surrounding 'Initiating Empathetic Opportunities' are closely correlated with the work of Suchman et al (1997). Where their findings related to recognising empathetic opportunities and attempting to get the patient to elaborate, the findings in this project revealed that there were a number of communicative strategies that the medical student used to aid in the occurrence of such opportunities. For example, rapport building was analysed relating to both the positive and negative face of the simulated patient. Through the combination of enhancing the simulated patient's face, and mitigating any potential threats to it, a safer atmosphere was created for the simulated patient to open up to the medical student about his or her emotional concerns. This was further enhanced through the negotiation and interruption of the agenda by the simulated patient, which offered a chance to openly discuss, or at least hint at, underlying concerns in the consultation. Where these clues occurred, Suchman et al.'s model then became important with the use of a 'continuer', in an attempt to explore the patient's thoughts and feelings further. Additional opportunities for the patient to hint at emotional concerns were provided through the 'state then relate' technique, where the medical student made a statement about the disease, and then asked if this statement resonated with the patient's lived experience of the illness. Through the student making the generic statement first, it made the situation more comfortable for the simulated patient, as it demonstrated that associated experiences the patient may have had were to be expected. Thus it aided in the simulated patient opening up to the student. In other cases, reassurance strategies such as statements involving the understanding of the patient's lived experience helped construct opportunities for empathetic interaction.

These were with reference to deducing the patient's emotional state and then giving the patient the chance to correct, agree, or disagree with the statement.

Norfolk et al.'s (2007) model of empathy in rapport establishment was also augmented by the results from this study, particularly with regard to the techniques involved in trying to understand the patient. Their model focused more on the cognitive mechanisms involved in empathy, whereas the findings from this project related to the process beyond this: the expression of the cognitive aspect and the resultant additional information gained from the patient. This was the case with the consideration of the simulated patient's feelings, notably verbalising opinions on the patient's thought process, considering the patient's lived experience of the illness, and also the medical student's capacity to delve deeper beyond the surface concerns of the simulated patient. Moreover, the student's concern of the simulated patient's immediate and continuing comfort also related to this, especially in situations where the patient was asked if he or she needed to pause the consultation due to discomfort. More obviously, the rapport which was discussed as a part of their model was also present here, with the division between negative and positive face strategies being noted as empathetic acts.

The work of Sonnex (2008) linked with trying to understand the patient. His paper emphasised the need for patient centeredness and foregrounded the need for doctors to avoid discouraging their patients from expressing their thoughts and feelings. He also noted the need to not just consider physical symptoms, but how they impacted on the patient on an individual level. This is supported by a number of the techniques coded as being involved in empathetic expression in this research. As alluded to previously, 'state then relate', checking the patient's comfort, and considering the lived experience were involved in this process. In addition to these, the medical student tailored the consultation to fit around what the patient already knew about the disease by checking the patient's starting point. In some cases, the medical student linked the disease to the patient's lifestyle and occupation, although consideration of personal life was somewhat absent.

Many of the observations made in Roberts et al.'s (2003) paper, which related to avoiding a breakdown in empathetic communication, were apparent in this study. What Roberts et al. referred to as 'attentive listening' was paralleled in the data, and was coded into two categories: information retention, and then the attachment of this information to the patient. Moreover, the ability of the medical student to judge how much the simulated patient had comprehended was augmented through checking that the patient understood what the student explained, and checking the student understood what the patient was saying about their experiences of the disease. Assumptions about the patient were avoided to an extent through checking their starting point; however, a few cases, where the student made assumptions about patient's thoughts and feelings, were coded as empathetic. This is most likely due to the simulated patient appreciating the medical student's motivation in trying to understand the problems. The assumptions themselves were mitigated to an extent through the use of the word 'sounds', where room was left for the simulated patient to rectify or clarify the medical student's understanding of the simulated patient's feelings. Other strategies for avoiding a breakdown in empathy were also present, such as the avoidance of patient labelling, jargon, and use of the first person plural pronoun 'we'. However, the concept of a 'crux' was not coded as empathetic in this study, but this was probably due to the coding system employed which focused on the micro aspects of the consultation, rather than the macro, or holistic, aspects.

Lexical choice, which was related to empathetic expression in a number of studies (Coulehan et al., 2001, Cordella and Musgrave, 2009, Roberts et al., 2003), was also coded as a potential empathetic strategy in this data. The use of euphemisms, and the avoidance of jargonistic terms, helped avoid or mitigate loss to the patient's face. Regarding emotionally-charged words, there were instances where the medical students avoided using certain terms – most notably 'cancer', and in a number of cases, this led to the patient's concerns not being fully addressed. Cordella and Musgrave (2009) also discuss the length of pauses and missing TRPs, and there was one very interesting example in the data which was related to both of these topics. In 014-44, the medical student says 'I'm sorry to hear that'. The simulated patient then pauses for over a second, but does not take this to be a TRP. This leads to the student holding the floor, and moving the consultation on to focus on the physical symptoms

of the simulated patient, rather than focusing on the simulated patient's actual worry about cancer.

The definitions of empathy which were used in some approaches (Wynn, 2005, Martinovski et al., 2007, Duan and Hill, 1996, Davis, 1990, Bachelor, 1988) were paralleled in this data. Although it was beyond the scope of this thesis to compare and contrast these definitions, a closer examination of the links between these may prove valuable, and could be considered as an area for further investigation. The mitigation and cooperation strategies found in other research (Martinovski et al., 2007) were also applicable here, and featured heavily in the analysis chapters. However, the use of tag questions (Martinovski et al., 2007, Harres, 1998) were not coded in the data as empathetic. It is unclear as to whether this was because the acts were missed by participants, or simply not deemed to be empathetic, but this could indicate the drawback of using predetermined definitions rather than an inductive approach to code where empathy is present in the data.

10.4. LIMITATIONS

There were several limitations to this project, which included aspects of the coding method, the scenario choice, and the generalisability of the research findings across the healthcare field.

Participants may have coded aspects of the consultation as empathetic as a result of 'looking' for empathy. If they had not been informed of the study's preoccupation with empathy, then participants may not have associated certain acts with the concept. However, the problem here is that if they had not been asked to code what they thought empathy was, then the exploration of the concept could not have been undertaken. In a similar manner, the fact that the role-players and students were familiar with the Calgary/Cambridge model of medical consultations meant that they may have been more likely to use the model as a basis for their coding. This could have been an issue, as the results did seem to reflect that empathy was expressed through various aspects of the model. However, this ranged from the relational aspects, to the structural aspects, rather than just focusing on RAV, which is the part

of the model which correlates most strongly with empathetic expression. While the danger of participants searching for something that was not there was a possibility, it was overcome to an extent through the triangulation of the participant coding, the axial coding and the focus group validation, although still must be considered a potential limitation to the study.

In addition to this, the actual interpretation of what the role-player and student had coded as being empathetic was also limited in the sense that once they had written down where they thought empathy had been expressed, it was the responsibility of the researcher to interpret exactly where in the consultation this was occurring, and why it was coded as being empathetic. In many cases, this was a simple process (for example, when an act involving the student asking about the patient's comfort was involved); however, in some cases this was slightly more ambiguous, and could have numerous interpretations. This could have been overcome with an additional section on **FORM 3E** asking the participants to explain what they thought was empathetic about the act they had coded, and this would be something that future research should incorporate.

Another limitation related to the coding was that it was that despite the assistance of the medical student and simulated patients with the identification of empathy, it was still the researcher's responsibility to interpret where these codes overlapped. While this was generally straightforward in the majority of cases, it cannot be ruled out that participants may have coded the same part of the consultation as being empathetic, but for different reasons. Moreover, the researcher's knowledge of empathy prior to the coding sessions could also be deemed a limitation of the research. The necessity to consult literature for ethical approval, transfer to PhD, and situating the research meant that these experiences may have affected my own interpretation of the concept of empathy. However, it could be argued that this makes the coding conducted by the researcher relate more strongly with an academic perspective, rather than the lay perspective I had when I first began the research.

There was one example of a deviant case within the data that related to the coding methods. This pertained to the sub-category 'Positive Proclamation' in Section 9.1.7.

The finding seemed to be associated more with basic politeness than the concept of empathy; however, it raised the issue of whether a holistic view of the concept of empathy should incorporate basic politeness as a constituent, and this is an area for further work in both medical education, and sociology. Another limitation relates to the coding of gesture in the project. While it has been discussed at greater length elsewhere in the thesis (Section 7.4), it warrants mention here that the majority of the coding was concerned with the linguistic aspects of communication, despite many of the participants insisting that the non-verbal aspect of empathy was as – if not more – important than the verbal. Hence, further work may be required in this area to decipher the non-verbal aspects of empathetic expression

There were also limitations relating to the scenario used in the research. Due to the nature of the methodology, only one scenario was used. While this increased comparability between consultations and coding, it meant that the transferability and generalisability was more restricted. For example, the scenario was based in primary care; if a scenario from secondary care had been chosen, then the results may have varied. While many of the findings might be useful in different cases, it must be remembered that they are contextually specific to this research, and so any attempt to transfer them to other circumstances must be met with caution.

The choice of simulated as opposed to authentic consultations must also be raised with regard to the project's limitations. While this served the purpose of examining empathetic expression within medical education, it was specific to education at the UEA, and not necessarily generalisable to other medical schools, or authentic consultations. On a related note, the generalisability to different cultural contexts is also limited, as both role-players were white British, which helped with the comparison across consultations. If they had been from different cultures, then the findings may have varied, although this was beyond the remit of this research, and is an area for further work.

The final point to make regarding the limitations of the research regards how the findings may be disseminated to medical students. At the UEA, and at other medical schools, there are numerous pressures on timetabling, with so much vital content to

incorporate into the medical degree. Hence, the best method of teaching the students about the findings from this study would be to incorporate them into the current consultation skills programme. At the UEA, the concept of empathy is given most scrutiny in the first year, where students have a lecture and consultation skills session on the concept. However, previous research suggests empathy is at its highest level in first year (Chen et al., 2007) and that it declines, reaching its lowest point in the third/fourth year (Hojat et al., 2009, Chen et al., 2007). Hence, it may be most beneficial for the results from this research to be incorporated into the third year of consultation skills teaching, as it would act as a form of revision and enforcement of what students learnt in the first year, and also tie in with the concept of shared decision-making, which is explored in the third year.

CHAPTER ELEVEN: CONCLUSIONS

11.0. INTRODUCTION

This chapter looks at how the findings from the thesis can impact upon both the educational aspects of medicine and also its associated clinical implications. The chapter also provides a discussion on further work to augment and enhance the conclusions from this project, and help steer future work in a direction that can build upon the methodological and philosophical approaches applied within the thesis.

11.1. EDUCATIONAL AND CLINICAL IMPLICATIONS

This section discusses educational *and* clinical implications, as it is anticipated that improvements in medical education will ultimately contribute to improvements in clinical practice. Many of the findings from this research may be implemented in the consultation skills teaching at UEA to augment the Calgary-Cambridge model, and might also be applicable to other medical schools using a similar system.

It appears that the most salient finding from this research relates to the medical students needing more detail on how and why acts are deemed empathetic; students and patients may benefit from a better understanding of why obtaining a patient's ideas, concerns and expectations is so crucial to empathetic expression. The section is divided into two main sections, which discuss the macro and micro elements of the findings. The use of the term 'macro' here refers to the overarching structure and progression of empathy within the consultation: it is the overall 'feeling' that the patient may have at the end of the consultation regarding whether or not they felt that the physician was empathetic. The micro aspect relates to the specific interactional moments and/or sequences within the consultations, particularly the sociolinguistic features.

11.1.1. Macro Empathy

The focus group's comments seemed to indicate that the concept of empathy, and its establishment in the interaction, begins outside of the consultation. Although this is not directly related to training, it may be useful to point it out to the medical students, so they are aware of the external factors which may hinder or help the empathetic content of their consultation. An example of the administrative importance came from the focus group, when P2 described the following, relating to administrative importance:

> *'It actually goes a bit further back than that because my wife has blood tests for regular bits and pieces in terms of the doctor's letter just said 'the doctor wants to see you' and we couldn't go for a week so you have a week thinking 'what is wrong'? (11-13)*

To improve upon this scenario, it may be beneficial for the physician to have alerted the patient to the fact that they would be testing for certain conditions in the previous consultation, and then call them in to confirm or reject the diagnosis. Hence the patient would already have some knowledge of the condition they may have, and the physician would not have to explain a potentially upsetting diagnosis to a distressed patient, who may not be able to take the information in. However, in this specific scenario, the blood tests were unrelated to the content of any previous consultation, and thus the use of the neutral message seemed justified and the best possible method of calling in the patient. However, it must be stressed that if this type of letter goes out, then ideally the patient should have the opportunity to see the doctor as soon as possible, so they do not have to wait and potentially become stressed or anxious about it. In relation to Grice's maxims (1975), it could be deemed that the letter saying 'the doctor wants to see you' is flouting the manner maxim, as the letter is being ambiguous in not giving the patient enough detail on the matter. However, obviously the letter could not divulge a diagnosis, and so the best method of dealing with this would seem to be for the patient to have the option of seeing the doctor on an emergency basis, although this is not something which is always practical,

especially if the doctor's letter refers to something routine that they just need to check with the patient.

Another issue which arose from the focus group was the issue of the average duration of a consultation. If patients have a much different view of how long a consultation should last, then this is an issue which should be addressed through educating patients, and this may be achieved either through standard education systems (schools, colleges) or alternatively, what one of the PPIRes members said occurred in his surgery: notices in the waiting room declaring how long a patient should expect their consultation to last (note that I have observed this in a number of practices, but not all – it may prove advantageous to make this compulsory in all GP surgeries). Moreover, it may also be beneficial to educate patients about what they can expect from the content of a consultation. For example, what questions they might expect to be asked, what the doctor is most likely to need to know; this may seem obvious, but if a patient does not frequently attend the doctor, then it may seem foreign to them, and thus a better understanding could help both them, and the doctor.

The above discussion of the administrative importance to empathy in the consultation seems to suggest that empathy may be seen as not simply one or two 'moments' in the consultation, but that these moments fit together as a whole to create an overall empathetic ethos. Simply stated, it could be argued that empathy is an integrative practice in medicine, and this is largely reflected within the Calgary/Cambridge model. However, it appears that the use of RAV (Recognise, Acknowledge, Validate) is not the only method of displaying empathy to a patient, but that the other mechanisms in the model, such as eliciting ICE (Ideas, Concerns, and Expectations), structure, and checking understanding all contribute to the overarching empathy.

From experiences in teaching, it seems that a majority of medical students see acquiring the patient's ICE as a box ticking exercise to obtain marks in OSCEs, without understanding why it is needed, or why it is useful. This links to the finding concerning the attempt to understand the patient's experiences. Obtaining the

patient's ICE is not designed solely for the doctor/medical student's benefit, nor should it be seen as a tick box exercise; it is also for the patient's benefit. The results indicated that understanding the patient's perspective was of paramount importance to the success of both building empathy, and the consultation as a whole.

Obtaining a patient's ICE near the start of the consultation is advantageous, as the medical student/doctor may then tailor the consultation around this, and also link back to it when giving information. The method in which the medical students attempt to discover the patient's ICE is not always exhaustive; students often ask outright about the ICE and take the patient's answer at face value, rather than exploring further and getting to the underlying ICE. The strategies found in this research can assist with both these issues, helping the student to build a clearer idea of the patient's thoughts and feelings. They may be used in conjunction with the current method of teaching, and serve to act as an extension to the Calgary-Cambridge guide, reinforcing and making explicit which acts are associated with empathetic expression.

The scenario used in this research meant that the simulated patient was meeting the medical student for the first time; hence the contextually specific nature of the consultation affected the way that ICE functioned. If the student/doctor consulted with a patient they had seen before, then they should have obtained the patient's ICE in the previous consultation, and hence may refer back to it in the follow-up consultation. Of course, it is still beneficial for the student to elicit the patient's ICE in the follow-up consultation, as they may have missed something before or the patient's ICE may even have changed.

A medical student may express empathy – and through this process obtain a better understanding of a patient's thoughts and feelings – through verbalising the thought process of the patient, considering the patient's lived experience of the illness, and also considering the patient's underlying concerns about an illness. Being aware of these aspects may improve the medical student's ability to obtain a more accurate representation of the patient's thinking, and as such tailor the consultation to his or her needs, and address the true motives for seeking medical advice. Integrating the

patient's needs in the consultation may also be enhanced by checking his or her starting point before giving information, checking the desire for knowledge, and considering the impact an illness may have on the patient's lifestyle – including both their occupation and personal life (hobbies, interests, etc).

The key aspect with the above techniques is for the medical student to realise the purpose and value in obtaining background information, such as ICE, from the patient. Moreover, the purpose of acquiring the information is not just to obtain marks in OSCEs or run through the motions of a consultation, but that it serves a practical purpose as well. It must be made clear that this can be applied and utilised throughout this and any subsequent consultations, in order to increase the relevance of the consultation to the patient's wants and needs. At the same time, the process of this may be deemed empathetic by the patient, hence it not only enhances the consultation with regard to the content, but also the emotional aspect, and adds to the overall 'macro' empathy in the consultation.

11.1.2. Micro Empathy

Even aspects of the consultation not obviously directly linked with empathy (for example, the structure of the consultation) can add to an empathetic ethos, and help guide the patient. The development of rapport and agenda setting in particular were shown to aid in the initiation of empathetic opportunities on the medical student/doctor's part, rather than simply as a response to the patient (Levinson et al., 2000). Levinson showed that in the majority of cases, physicians passed up opportunities to discuss emotions when patients gave them the chance. This research however has explored some of the ways these opportunities arise through what the medical student says, and these were discussed in relation to what shall be termed here as the micro-interactional aspects. By using the term 'micro', it in no way diminishes the importance of these techniques, but differentiates them from the more general techniques discussed previously. Hence, the 'micro' here refers to the empathetic devices which are used at specific moments in the interaction, rather than the overall general 'feel' that some other devices (administrative importance, background information about the patient) produce. Here, the micro specifically

concerns politeness theory (Brown and Levinson, 1987) and the cooperative principle (Grice, 1975). During consultation skills training at the UEA, many medical students provide feedback on the macro aspects of the consultations, with statements such as 'it was really good', and 'you were really empathetic' being commonplace. Apart from being vague, the usefulness of this type of feedback to the student undertaking the simulated consultation is limited. An understanding of the micro aspects of the consultation, as well the macro, may be advantageous to both the student feeding back and the student conducting the consultation. For example, understanding the micro aspects may mean the use of certain interactional techniques and feedback on these techniques in seminars would become more common, and hence improve the educational experience for the students.

The findings in this thesis indicated that it may prove useful to educate the medical students on how and where empathetic opportunities may arise in the consultation. For example, a more thorough understanding of agenda setting, including strategies on negotiating a shared agenda by allowing the patient to contribute and interrupt, may help ensure that both the patient's and student's agenda have been covered satisfactorily. Furthermore, checking the understanding of both parties can further enhance empathetic communication. It is important for the medical student to realise that it is not just the information they give to the patient which needs to be checked for comprehension, but the information the patient is giving to the student. The medical student must not assume that they have understood the patient, or that the patient has understood the student. Reassuring the patient by directly acknowledging their concerns, rather than avoiding them, may also improve empathetic expression. Medical students must be given adequate confidence and reassurance so that if they believe a patient is referring to a taboo subject such as cancer, then they verbalise this and make it explicit. This is an issue which seems most difficult when teaching the younger students who joined the MBBS programme straight from school, rather than taking a gap year or completing a previous degree, and it may be beneficial for more attention to be given to this in the consultation skills sessions – especially those in the first year sessions (although this is based on the researcher's ethnographic observations in teaching, rather than being generalisable from the research findings here).

Another confidence related issue involves the medical student's desire to not impede the patient's face by telling them something that they do not want to hear, such as a objectionable treatment regime. For example, if a patient initially seems to object to a certain treatment, but the medical student/doctor knows that the treatment is the only one that can potentially save the patient's life, then they must have the confidence to explicitly state that there are no other options. They may also need to help the patient to see the logic in their argument, rather than skirting around the issue and being ambiguous, which (from my observations) is a problem that occurs frequently in consultation skills training at UEA.

The findings also demonstrated how various aspects of the Calgary/Cambridge model incorporated opportunities for expressing empathy, and that these opportunities were not just related to the concept of RAV. While RAV is a useful method to help deal with the patient's emotions, it is one of many methods that can be used, and this should be made clear to students – especially those who gravitate toward thinking that using the RAV technique a couple of times in a consultation makes them appear empathetic. While it is useful to use in places, the findings here imply that empathy is an integrative practice, and that the use of the micro techniques used to express empathy may contribute to the overall empathetic ethos of a consultation.

Medical students may also benefit from a basic understanding of the concept of face (Goffman, 1967). Rapport is mentioned in the Calgary-Cambridge model as a part of building the relationship, and it is also discussed in other literature (Norfolk et al., 2007). However, detailed information about the micro-interactional aspects which are involved in the establishment of rapport are not addressed thoroughly in the UEA consultation skills training. Hence, teaching medical students about the findings from this study involving positive face (offering, praising, interest taking, agreeing), and negative face (apologising, suggesting), may assist in their aptitude to connect with the patient. An understanding of face also may make it clearer to students why devices such as euphemisms, jargon evasion and praising the patient are all methods in which they can express empathy with the patient.

The above is also true in relation to the cooperative principle (Grice, 1975), which can assist the medical students to become more reflexive and considerate of the patient's thoughts and feelings within the consultation. It could give the students a better understanding of the overall construct of the consultation, and make them more attuned to what certain interaction on their part may lead to later in the consultation. It may be useful to highlight here that the desire for the medical student to adhere to this, and become more reflexive and considerate of the patient, creates an almost paradoxical element to the way they are currently trained and recruited. There is an expectation for medical students to be reflexive in their practice. This is encouraged by the GMC guidelines (GMC, 2009) and the necessity to produce a portfolio in order to graduate from UEA. However, the nature of the medical profession means that even by the time the students have been recruited to the programme, they are already highly competitive individuals, with the best exam results from school and/or previous degrees. This continues through medical school, with constant (and necessary) examination, and is reflected in the students' drive to come as high as possible in the OSCE quartiles. It could be considered that this may lead to training and the practice of medicine shifting the focus from caring for the patient and being reflexive in relation to their training, to personal achievement and progression. While examination can help drive reflexive practice, there is also a danger that students become too focussed on passing the exams, and less on personal development, and this is an area which should be monitored closely, and may profit from further research.

Referring to a previous example, a number of third year medical students objected to the necessity of obtaining a patient's ICE, as they did not see how it benefited their ability to make a diagnosis. This relates back to the point made in Chapter Two about the role of the doctor being first and foremost to care for the patient, and secondly, to cure (especially in relation to chronic illness). Eliciting and listening to the patient's ICE may not only provide the medical student/doctor with valuable information about the problem, but also can have a therapeutic effect. Hence, a more thorough understanding of the micro-interactional elements of the consultation, such as politeness and cooperation principles, may help illuminate why empathising with

the patient in order to better understand their thoughts and feelings is so important to the consultation.

11.2. FURTHER WORK

The purpose of this study was to explore how empathy was perceived to be expressed in medical education. While it revealed numerous ways in which this occurred, the study did not detail information about the levels of empathy being expressed; hence, one empathetic act may have been considered weightier than another. To combat this, a quantitative aspect could be introduced into further research, similar to the method used by Roter et al. (1989), where what was deemed to be an empathetic speech act was also given a quantitative rating. A quantitative angle may also prove valuable in terms of ranking the consultations overall. For example, in this research, PPIRes were adamant that participant 003 was holistically more empathetic than 010. Rating the data in this way was not possible within the scope of this thesis, as it would have required a large number of participants to be statistically significant, and would have ultimately been another project in itself; however, it is an area of potential for future work.

While some gesticular and non-verbal information was coded by participants, the majority of the coding concerned the verbal aspects of the consultation, and it was unclear as to whether this was because empathy was deemed to be expressed more through verbal means. If it was, then this finding was in opposition to the opinions of the focus group, who insisted that expressions of empathy had more to do with what was not said. It could be argued that picking up on non-verbal and gesticular features is not something that humans do at a conscious level; hence this would explain why the emphasis for empathetic expression was put on the verbal element. In future studies, this confounder may be addressed by either removing the sound from the data, or the tone of voice and intonation from the participants, before showing the data to coders.

Future research into the area may also profit from the use of different scenarios. While the same scenario involving haemorrhoids was used in this project to enhance

the transferability across consultations, using different scenarios with different foci may reveal additional information about perceptions of empathetic expression. Moreover, to test the framework developed as a part of this project, a scenario based on the framework developed here could be scripted and acted out. This data could then be taken to a large group of patients (chosen through random or stratified sampling) to code where they perceive empathy to be expressed. Where overlap occurs between their opinions and the sections of the consultation which were expected to be coded as empathetic from this research, it would enhance the trustworthiness of the framework. If disparity occurs in the data, then the framework would have to be adapted to incorporate this.

In addition to alternative scenarios, it may also be valuable to apply the methodology devised in this thesis to incorporate medical students and simulated patients from other medical schools in the United Kingdom, or internationally. It may be of particular interest to examine cases where the medical school in question does not follow UEA's philosophy of starting consultation skills training in the first year, but delays it until the third year of training. The potential disparity in empathy between the two sets of subjects may give further indications, and build on existing research, as to why empathy supposedly declines so rapidly in the third year of training (Hojat et al., 2009). Finally, the methodology used in this project could be expanded from medical education to incorporate authentic consultations, with a doctor, patient and researcher coding the data. This could then be compared and contrasted with the findings from this research to indicate how perceptions of empathy in medical education represent the reality of practice, and thus help solidify the link between the two.

11.3. CONCLUSIONS

From the analysis and subsequent suggestions for the enhancement of consultation skills training, it appears that the current method of teaching using the Calgary/Cambridge guide incorporates a large proportion of the skills required for expressing empathy in medical consultations. Moreover, from the findings obtained from this thesis, it appears that empathy may be seen as an integrative practice,

which exists throughout the consultation. It begins before the interactional element, with structural and bureaucratic factors potentially influencing its development. Many of these skills used throughout the consultation are more subtly related to the concept of empathy, and it may not be obvious in consultation skills training why these are linked. Hence the medical students may not use the various techniques, as they may not see them as being important, or useful, to the consultation. Through exploring the interactional elements of the consultation (for example, the ideas of face and cooperation, as discussed in this project), this understanding may be enhanced, and the students may become more willing and able to use the techniques. It may seem that these techniques are automatic and subconscious, but it is only when examined in detail that it becomes obvious as to why they are paramount in consultation skills, and how they relate to empathy (namely the wants and needs of the patient).

The analysis also indicated that empathetic opportunities can be created, which related to, and built upon, previous research in the field (Levinson et al., 2000). This also leads on from the point made above: that through the consideration of the interactional techniques, one can set up more opportunities to be empathetic with the patient. It is also vital to emphasise the effects of using the micro-interactional elements of the consultation. Once medical students have an understanding of the results that can be achieved from utilising a certain technique, they may make them more willing to use it. Again, this is about guiding the students in their understanding of how to run a consultation, rather than telling them specifically how to run it, which can often result in very mechanical and artificial interaction. It should be the medical student's responsibility to adapt and integrate the techniques discussed in this thesis, and the Calgary/Cambridge model, into their own consultation, in order to make the interaction more natural.

One of the aspects of the research which proved less rewarding was the difficulties faced with coding gesture and non-verbal behaviour. As discussed earlier, future research in the area which utilises member coding could make an effort to oblige the coders to focus on gesture or non-verbal behaviour specifically, although further study and methodological innovation may be required for this to be achieved.

Despite this, the inductive approach and incorporation of member coding provided a less biased method of analysis, and helped to understand the overlaps between perceived empathetic expressions. The explication of this analysis also demonstrated the close link that politeness theory (Brown and Levinson, 1987) and the cooperative principle (Grice, 1975) possess in relation to empathy. Most importantly, the thesis has highlighted that while empathy exists and may be expressed at numerous 'moments' in the interaction, these 'moments' interconnect to develop the concept of empathy as being an overall integrative practice in undergraduate medical education.

APPENDIX

Glossary of Acronyms and Abbreviations

Acronym or Abbreviation	Referent
ASSIA	Applied Social Sciences Index and Abstracts
BEES	Balanced Emotional Empathy Scale
BNC	British National Corpus
CA	Conversation Analysis
CARE	Consultation and Relational Empathy Scale
GMC	General Medical Council
GP	General Practitioner
IBS	Irritable bowel syndrome
ICE	Part of the Calgary-Cambridge guide; refers to the need for a doctor to elicit a patient's **I**deas, **C**oncerns and **E**xpectations about their condition
IRI	Interpersonal Reactivity Index
JSPE	Jefferson Scale of Physician Empathy
LLBA	Linguistics and Language Behaviour Abstracts
MB/BS	Medical Bachelor/Bachelor of Surgery
NVivo	Non-numerical Unstructured Data * Indexing, Theorising and Searching Vivo

Acronym or Abbreviation	Referent
OSCE	Objective Structured Clinical Examination
PPIRes	Public and Patient Involvement in Research (focus group)
RAV	Part of the Calgary-Cambridge guide; refers to the empathetic aspect of **R**ecognising, **A**cknowledging and **V**alidating a patient's emotions
RI	Barrett-Lennard's Relationship Inventory
RIAS	Roter Interaction Analysis System
TRP	Transition Relevance Point
UEA	University of East Anglia

Transcription Conventions

Transcription Symbol	Referent
[	*A left bracket* indicates the point of overlap onset.
]	*A right bracket* indicates the point at which two overlapping utterances end, if they end simultaneously, or at the point at which one of them ends in the course of the other. It is also used to parse out segments of overlapping utterances.
=	*Equals signs* indicates no break or gap. A pair of equals signs, one at the end of one line and one at the beginning of a next, indicate no break between the two lines.
(0.0)	*Numbers in parenthesis* indicate elapsed time by tenths of seconds.
-	*A dash* indicates a cut off.
::	*Colons* indicate prolongation of the immidiately prior sound. The longer the column row, the longer the prolongation.
__	*Underscores* indicate intonation contours. Basically, the underscore 'punches up' the sound it occurs beneath.
↑↓	*Arrows* indicate shifts into especially high or low pitch.
WORD	*Upper case* indicates especially loud sounds relative to the surrounding talk.
°word°	*Degree signs* bracketing an utterance or utterance-part indicates that the sounds are softer than the surrounding talk.
> <	*Right/left carats* bracketing an utterance or utterance-part indicate that the bracketed naterial is speeded up, compared to

	the surrounding talk.
< >	*Left/right carats* bracketing an utterance or utterance-part indicate that the bracketed material is slowed down, compared to the surrounding talk.
.hhh	*A dot-prefixed row of 'h's'* indicates breathiness.
wohhrd	*A row of 'h's' within a word* indicates breathiness.
£	*The pound-sterling sign* indicates a certain quality of voice which conveys 'suppressed laughter'
word	*A word within asterisks* indicates percussive non-speech sounds.
( )	*Empty parenthesis* indicate that the transcriber was unable to get what was said. The length of the parenthesised space reflects the length of the ungotten talk.
(ø)	*A nul sign* indicates that there may not be talk occuring; that what is being heard as possibly talk might also be ambient noise.

Transcription Examples

The following section contains two of the transcripts (003 and 010) for reference. These are transcripts of the consultations which were shown to the focus group. In addition to these, the transcript from the focus group is also included for reference. All of the other transcripts from the project are available on the accompanying compact disc, which is included as a part of the additional materials.

Transcription Example 1: Participant 003

Student: hello (.) uh my name's (0.5) kieran (.) gilroy (.) and i'm a medical ↓student (.) may i just ask you your name

Patient: um (.) it's janice saunders

Student: °janice saun↑ders° (0.5) um (.) so (.) i have been asked to come and speak to you about your um recent diagnosis=

Patient: =yeah

Student: is that alright

Patient: that's f↑ine yeap

Student: great=

Patient: =well my niece is a medical student actually so[

Student: [oh right↑

Patient: i understand if that [helps

Student: [very helpful (1.0) um so would you mind just sort of um filling me in as to what's been happening so ↓far

Patient: um (.) i came to see my doctor here about six months ago (1.0) um (.) because i was really worried (.) about (1.5) the fact that (.) um i seem to be (.) um (2.0) um (.) °bleeding from the back passage°

Student: right

Patient: and erm (2.5) HE SAID that it was probably haemorrhoids

Student: right

Patient: but (.) said he thought (.) it would get better if i saw the um specialist which i have (0.5) °d-done°

Student: okay

Patient: and um (.) had some (.) tests and um had i had a sigmoid (0.5) oscopy i think[

Student: [yeah

Patient: i think that's what it's called

Student: yeah

Patient: and um (.) anyway consultant said he thinks (.) it is

Student: it is

Patient: yeap[

Student: [oh right

Patient: so i'm i'm just here today to sort of discuss (.) what the next step is really

Student: okay (.) okay (.) urrm (.) a::nd are you feeling okay about (.) having having a haemorrhoid (.) what do you want to (.)

to[

Patient: [well really er the worst thing for me i mean >um it is um embarrassing< it's not something that

you[

Student: [yeah

Patient: talk about to people[

Student: [sure

Patient: and um (1.5) but the worst thing for me now in the last six months since i came to see the doctor

Student: mmm

Patient: it's (.) it's (.) just excruciating actually

Student: is it °is it°

Patient: it <u>r</u>eally <u>r</u>eally is so i'm hoping that we can (1.0) get something sorted out

Student: okay (.) well °sure sure° it must be painful[

Patient: [mmm

Student: um (.) alright well >we'll we'll< really try and get something (.) sorted out=

Patient: =okay=

Student: =for you (0.5) um (.) did the doctor explain exactly WHAT haemorrhoids were and and (.) and things like that so do you understand what they are

Patient: well i'm not very clear as to what they are er er i t mean i know they're bumps and[

Student: [yeah

Patient: and (.) and um (.) and i know they're really painful

Student: okay

Patient: but that's about all i know really

Student: right well um (.) what i'll do then is just quickly (.) explain what they're (.) sorry are ↑you are ↑you=

Patient: =yeah=

Student: =uncomfortable

Patient: i am a bit uncomfortable (.) no i just if i just
position myself or thhh

Student: sorry i should have asked before (0.5) um (.) do tell me to stop if you're (.) uncomfortable at

any[time

Patient: [okay (.) thank you

Student: i'll just quickly go through what they are (.) and we can work out (0.5) treatment options and how to decide together what would be

[best for you

Patient: [great

Student: um (.) so basically haemorrhoids are um (.) the swelling of the lining of (.) your anus (.) which is the very bottom last bit of your um your digestive tract

Patient: oh right

Student: is that [make sense

Patient: [yeah yeah yeah

Student: um (.) and anything that causes (0.5) um an increase of pressure (.) on that on on on the um (1.0) on >on a digestive tract< will result in (.) in ↓haemorrhoids

Patient: okay

Student: um so the swelling is because there's a er (.) um there're a sort of small blood vessels (.) that can become eng↑orged with

blood and (0.5) that's what causes the swelling

Patient: okay=

Student: =okay[so is that is that make sense now

Patient: [well it's (.) it's interesting cos a friend of mine said she thought they were like a varicose vein but (1.0) [so it does sound it (.) yeah like yeah

Student: [yeah (.) well (.) yeah it's similar (.) and um (.) you i think have something called grade(.)grade two=

Patient: =that's what the consultant said yeah

Student: okay (.) which means that they they come out (.) um (.) but they pop back in (.) on their own so they come out when you go to the loo or something like that

Patient: yeah (.) yeah

Student: um (0.5) so in terms of things you can do to-t-to (.) in terms of treatment options (.) there are a (.) there are a few options available to us (1.0) um (.) the first thing you can do (.) yourself (.) is things ur like um er er diet (.) so (.) because (0.5) constipation and ↑diarrhoea make make it worse

Patient: and that's something that that i've tended to suffer from f-f-for quite a few years actual↑ly

Student: yeah

Patient: um (.) cos i well i think i've got IBS >it's never been diagnosed properly< but i've had it for about twenty years and at

seven or eight years ago (.) >↑i think it must've been in the papers< quite a lot around that time and the symptoms were very similar to mine so

Student: okay

Patient: so i do go through times of either (1.0) y'know being really constipated

Student: yes

Patientl or the opposite

Student: yeah (.) okay (.) well both those things and particularly constipation happen when you're under stra:in to go to the loo (1.0) um can make haemorrhoids worse (.) so if you (.) modify your diet (.) and eat lots of fine pa::[

Patient: [yeah

Student: basically you get things moving as easily as possible (.) can help with the pain and discomfort

Patient: right

Student: um (0.5) as well as (0.5) drinking lots of fl-lots of fluid and things like that

Patient: right

Student: just to get things moving just and just to stop straining like tha::t °on the toilet°

Patient: okay

Student: that might help °on the toilet that can help° the other thing (.) which is totally non in↑vasive is is creams n you get creams just over the counter[

Patient: [mmm

Student: and they they don't deal with the problem but they can help with symptoms (.) so they can help just um just ease the ease the pain

[and irritation

Patient: [right (.) okay

Student: um in terms of (.) um dealing with the actual ↓problem (.) are you okay there do you want me to stop

Patient: no you're okay

Student: okay (.) in terms of dealing with the problem there are a couple of umm sort of out out patient procedures tha-that um (1.0) that tend to be done when (.) grade (.) ur (.) ↑two haemorrhoids which is what you have

Patient: yeah

Student: the most the most common one is (.) something called a ↓band ligation=

Patient: =right=

Student: =did the doctor[mention that

Patient: [no (.) no he was a man of few words actually at the hospital

Student: okay (.) al↑right

_____

|

(⌀) (1.0)

|

Patient: _____ mmm

Student: okay so would you like me to[go through that

Patient: [i'd love it (.) thank you

Student: okay basically a band ligation (.) sounds complicated but all it is (.) they it's like a like rubber band and it's under local anaesthetic so you won't be (0.5) out >you'll be awake<

Patient: mhmm

Student: urmm (.) and they just (.) put put the band um at the root of the haemorrhoid (0.5) and it should drop off basically to cut off the blood supply to that haemorrhoid

Patient: right

Student: then in two or three days it should drop off (1.0) generally a-a-a painless procedure and it is quite is quite successful

Patient: oh okay

Student: ummm so eight out of ten (0.5) patients who who do that uurm °would be in primary care°

Patient: right

Student: okay

Patient: mmm

Student: that's the common out-outpatient procedure that we can do (.) um as an outpatient (0.5) um (.) if things progress <if that doesn't work> there are other (.) other urm (.) other procedures so we can do something called ssst ah well it's

243 basically an in-injection of um a chemical
244 which does the same thing >basically cuts
245 off the blood supply<

246 Patient: WHAT in°to°

247 Student: into the into[the haemorrhoid yeah

248 Patient: [huuuu

249 Student: um

250 Patient: that sounds terrible

251 Student: it does sound terrible actually doesn't it
252 but it's not IT'S NOT supposed to be
253 painful (.) but it is less successful than
254 a band ligation

255 Patient: ah right uh well uh (.) to be honest i'm
256 i'm not inclined to toward any ↑surgery
257 generally but

258 Student: mhmm

259 Patient: if i thought that it was something that
260 would definitely (0.5) solve the problem
261 for me i think i would consider

262 Student: okay=

263 Patient: =surgery because it's just got so bad

264 Student: right

265 Patient: especially with work and stuff and so

266 Student: how has it impacted on your

267 Patient: well um my husband and i have our own
268 business we're book binders and printers
269 (.) we work from home but it does mean
270 that (.) i'm very sedentary actually at
271 work

272 Student: yeah

Patient: and it um i've ended up now °°i'm sitting on this little circular cushion°°

Student: yeah

Patient: cos it's the only wa:y i can bear (0.5) to be still

Student: yeah

Patient: so (.) and it and it is affecting (0.5) you know because it makes life so uncomfortable

Student: sure sure (1.0) so you really want to get

Patient: i really want to get this sorted out (.) yeah

Student: okay (.) well so would you be leaning towards something like a band ligation would that

Patient: well it well if you think that ↑that would be (0.5) something that would sort it out for me i'd be prepared give it a go yeah

Student: hmm yeah yeah (.)and um would ↓you err like more information on ↑sort of (.) more um invasive surgery at the moment

Patient: well if there is anything i might as well

Student: okay well well if that doesn't work and as i say it works in the vast majority of patients

Patient: mmm

Student: okay (.) but if that doesn't work there is errm more invasive surgery which would be done under general anaesthetic

Patient: right

303 Student: um (.) and there are various sort dif
304 different ways of of doing it effectively
305 (.) n the-they cut out the haemorrhoid

306 _____

307 |

308 (⌀) (1.5)

309 |

310 Patient: _____ cuu right (.) so i bet they're gone
311 for good then

312 Student: so they're they're gone for good i mean
313 ↑both ↑both those methods would (.) would
314 hopefully treat it (.) for good

315 Patient: yeah

316 Student: but um the more invasive surgery something
317 called a haemorrhoidectomy which is a big
318 word but

319 Patient: mmm

320 Student: that's urrm ef↑↑fective (.) but it's it it
321 can be associated with more ↓pain
322 afterward after the

323 Patient: which one is that one

324 Student: the the haemorrhoidectomy the one where
325 you cut it out n put on a[

326 Patient: [yeah suppose it
327 makes sense really yeah

328 Student: okay (.) so those uh those are the options
329 really umm (.) so (0.5) does that make
330 sense to you

331 Patient: yeah

Student: an-and >do you have any other sort of questions< or anything [that you'd like me to clarify

Patient: [um (.) i suppose that that er as i've been to the hospital and i've seen the consultant and he said that he thinks it is haem-haemorrhoids that that that is you know that that's what we're sort of talking about really and that that was it

Student: yeah

Patient: sort of thing

Student: y-y-yes yeah so (.) it is it is diagnosed as haemorrhoids nothing more serious °>than that<° which is [which is good news

Patient: [yeah (.) yeah

Student: um (.) you're in good company (.) fifty percent of the uk population will have haemorrhoids at some point in [their lives

Patient: [really cos you no one ever talks about it so you never (0.5) you never hear

Student: yep (.) yeah (.) well it's u awkward conversation=

Patient: =it is and everyone just laughs about it

Student: sure

Patient: and you don't realise until it gets to this point i think just how (2.0) HOW painful it is

Student: sure

Patient: and and WHY it's so painful

Student: sure (0.5) well you are in (.) in good company and it is very very treatable (0.5) um (.) so (0.5) just to wrap up then before we run out of time

Patient: okay

Student: do you have any kind of any issues or questions that you'd like to ask

Patient: um (2.0) no i was s i was wondering why (.) y'know they'd actually come on but having talked about the IBS bit and what you've explained about the constipation n everything it it makes complete sense that [that would be why it's happened

Student: [yeah

Patient: it's just a bit scary when you >when you see< any sort of bleeding isn't it

Student: sure

Patient: especially from the back

Student: yeah (.) okay well so the good news is that it is treatable (.) it's (.) nothing i know it's painful but it's not as SERIOUS in that sense

Patient: yeah

Student: um (.) so if you're leaning towards the band ligation (0.5) is that

Patient: well whichever is gona s-s whichever is going to ff stop it completely for me is what i'd like to do yeah

Student: well we'll probably then from now we'll go we'll head towards the band ligation and ↑hopefully that will work and if not we'll cross that bridge when we come to it

395 Patient: okay (.) okay

396 Student: um (.) so i'll give you some more
397 information about that and you can go away
398 and think about it

399 Patient: yeah (.) thank you

400 Student: okay (.) thanks very much (.) good bye

Transcription Example 2: Participant 010

Student: um hello mr saunders↑

Patient: that's right (.) yes

Student: hello my name's jen musto (.) i'm a fourth year medical student at u e ↑a (.) and um (.) i've spoken to your GP and (0.5) he suggested that i come and talk to you about some of the >problems that you've been having<

Patient: oh yeah that's okay yeah

Student: okay (.) well um before we begin are you comfortable

Patient: yeah not too bad thank you

Student: okay (.) um so everything we discuss will be confidential between ourselves and the GP (0.5) °okay° (.) um so first of all it'd be good for me if i could just get a few baseline questions out of the way (.) um like your occu↑pation

Patient: um (.) i'm actually uh a bookbinder

Student: oh (.) okay (.) and um (.) your age

Patient: i'm fourty two

Student: your fourty two (0.5) okay (.) thank you very much (.) and now if you could just begin by telling me a bit about what's been happening to you

Patient: oh okay well (.) umm (1.0) i (.) i went to the doctor (.) six months ago (.) cos uh (.) i was getting sort of a lot of (.)

pain in my (0.5) back °passage° (.) discomfort and so on (.) um (0.5) and i've had some sort of inkling about it for quite a long time >and i think i've got IBS< (.) y'know had that for a while as well (0.5) um he had a look (.) and um (0.5) since then had a sig-moidoscopy (0.5) uuum (.) and (.) i was told that i've got grade two haemorrhoids (0.5) um (.) i really want to get this sorted out now i mean it's just s-so painful and inconvenient and uh (.) i don't get a lot of sympathy really at home so (.) um if there's some some way to just clear them up once and for all that'd be great

Student: okay (.) so do you know much about haemorrhoids

Patient: um (.) something to do with blood vessels isn't it (.) um

Student: yeah

Patient: yeah

Student: yeah that's (.) that's correct (.) um would you like to know a bit about what haemorrhoids=

Patient: =yeah i think it would be useful yeah

Student: okay (.) well you're right it is to do with blood vessels and it's where they um (.) are sort of slightly larger than perhaps they should be and sort here's an (.) example uh (.) illustration i don't know if this is helpful

Patient: right

Student: and uh (.) here shows the different (.) uh sizes and you mentioned that yours is a grade two

Patient: yeah

Student: so that would be (0.5) this type here

Patient: ri[ght

Student: [and as you can see it doesn't come out (.) of the uh anal canal (.) it stays within (.) but it can give you (.) the symptoms that you (.) told me about

Patient: right (.) sometimes they do feel they're sort of (.) um protruding a bit but they go (.) back

Student: yes (.) yeah (.) and that's once you've passed a bowel movement

Patient: yeah (.) yea[h

Student: [right (.) okay (0.5) and so is there anything else that you (.) want to know about

Patient: well i mean i'm (.) i am quite concerned that it's um (.) not a sign of anything else (.) it (1.0) um (1.0) i mean the (0.5) the er consultant didn't really say an awful lot to me he was a bit sort of (.) y'know (.) quiet or something

Student: ri[ght (.) okay

Patient: [um (.) d'you (.) can you (.) i mean (.) do you >know if it's< anything i need to worry about or

Student: is there something that you have in mind

Patient: well my (.) um my dad had bleeding from his back passage and uh (.) it turned out he had bowel cancer

Student: right (1.0) okay (0.5) and is y'know is this something that concerns you

Patient: well you know obviously yeah (.) it didn't work out very well for him (.) i mean

_____

|

(ø) (3.0)

|

Student: _____ okay well i'm sorry to hear that (.) and um i (.) i think it's right that you are concerned because um in your father's case (.) um when there is bleeding in the back passage that can (.) um indicate that there's something serious going on

Patient: mm

Student: but it's important to remember that there's many <u>other</u> causes (.) for bleeding (.) um some as in-in your case haemorrhoids which is a very (.) uh benign condition (.) meaning that >y'know< it really is=

Patient: =doesn't feel that way °°but y'know°°

Student: um (.) i-i understand this must be difficult for you

Patient: yeah

Student: um (.) >but yeah< (.) i want you to be reassured that (0.5) they've found out what your problem is and (.) it is treatable

Patient: do you think they'd have looked to see if it was (.) cancer or not (.) or

Student: well with the sigmoidoscopy they would have been able (.) to check your um (1.0) the lower part of your colon

Patient: right

Student: and um (.) obviously that doesn't (0.5) exclude (0.5) everywhere

Patient: hmm-[no

Student: [near your bowel

Patient: so there's quite often blood on the (.) toilet paper and stuff

Student: right okay (.) and can you describe what the blood was like

Patient: it was red

Student: °°it was red (.) okay°° well um (.) often they say that when the blood is more fresh er red-dy colour (.) that's likely to be something from around the area (.) like haemorrhoids (.) or perhaps (.) if the blood was darker (.) or mixed in with the stool itself (.) that would indicate a bleeding higher ↑up

Patient: right okay

Student: so that would be something you could look for

Patient: okay

Student: um and then (.) you would (.) want to see your doctor about that (.) and if you were feeling unwell (.) if you (.) er lost weight (.) if your um bowel habits changed (0.5) that would be something (.) to (.) see your doctor about

Patient: right

158 Student: so has any of ↑that happened you

159 Patient: um (.) in terms of

160 Student: weight loss:: or

161 Patient: no (.) not really i've always been fairly
162 ( )

163 Student: okay

164 Patient: um

165 Student: well i think that-that's reassuring then

166 Patient: yeah (.) yeah i mean i (.) y'know (.)
167 obviously i have got (.) haemorrhoids so
168 it's probably that

169 Student: yeah

170 Patient: um (.) what kind of treatments are there
171 that i can kind of have (.) i mean is
172 there any way i can just clear it up once
173 and for all

174 Student: um yeah (.) there are lots of treatments
175 ranging from what we call conservative so
176 (.) just sort of doing very basic (0.5)
177 lifestyle changes (.) through to er
178 surgical (.) options (.) so um a more
179 definitive treatment would be the more
180 surgical procedures so do you want me to
181 go straight to ↑them or would you like me
182 to=

183 Patient: =could you just tell me what there is

184 [i mean i

185 Student: [yeah

186 Patient: on the one hand i want to (.) get rid of
187 them >but i don't< you know i don't want
188 to have surgery really

Student: okay

Patient: ( ) that

Student: of course (.) right (.) so conservative things would be (.) just helping (.) preventing getting them in the future (.) and easing some of symptoms that you are experiencing (.) so it's important to drink lots of ↑fluid (0.5) um try and have a high fibre diet so fruit veg bran things like that

Patient: thing is though obviously the (.) bran (.) i mean that (.) doesn't go with the IBS very well so

Student: right okay (.) well

Patient: gota be careful with some fruit as well (.) but okay i'll

Student: so fluids perhaps might be

Patient: yeah

Student: something that you could (0.5) try (0.5) also regular exercise (.) that can help

Patient: i do um (.) go for a walk (.) now and again y'know (.) i quite like to get out

Student: okay (.) well that's good (.) that's positive (.) um and then you can move on to (.) um things such as um injections (.) into the haemorrhoid itself

Patient: right

Student: ummm or you can use um like (.) a rubber b↑and (.) and that can be put (.) around the haemorrhoid (.) these will help the (.) sort of the blood supply diminish and eventually they'll drop ↑off (.) so that's

221 another option (.) and there's surgical
222 removal (.) as well

223 Patient: okay

224 Student: so there's a few (.) options there (.)
225 does any of them >sort of< °°sound
226 appealing°°

227 Patient: no hhh. not really

228 Student: hhh. sorry

229 Patient: well (1.0) i suppose the injection sounds
230 like the least (.) radical really beyond
231 just trying to not get them in the first
232 place

233 _____

234 |

235 (ø) (2.0)

236 |

237 Student: _____ yeah

238 Patient: umm is that very painful or

239 Student: they give you a local anaesthetic

240 Patient: oh right

241 Student: maybe it's a bit uncomfortable but it
242 shouldn't be painful

243 Patient: right (1.0) and that'd be suitable for the
244 level of haemorrhoids i've got would it=

245 Student: =yes

246 Patient: okay

247 _____

248 |

(ø) (1.0)

|

Student: _____ s'something perhaps you could talk to your doctor about

Patient: okay

Student: okay so we've kind of covered what haemorrhoids are (.) treatments (1.0) available to you (.) um like (0.5) maybe the sounds of the injection

Patient: maybe yeah

Student: so is there anything else (.) um (.) going on at the moment that you want

Patient: um (.) no not really um (2.0) nah i think i (.) if i could sort this out cos i (.) i have to sit down at (.) with my job y'know

Student: right

Patient: as i say my (0.5) partner's getting little fed up of me moaning about it so

Student: yeah

Patient: um

Student: cos you mentioned that earlier

Patient: well i think she thinks that i'm a bit too much sort of (.) making too much fuss really but (2.0) yeah she doesn't know what it's like y'know

Student: so has that been affecting you

Patient: yeah it's very (.) y'know very painful and (.) embarrassing (.) and y'know can't actually relax too much (.) go to the theatre of something like that (2.5) i

mean (.) maybe the injections would sort it out n then it'll be sorted out

Student: yeah (.) i mean it's important that to remember that there is a treatment (.) and y'know there's different options available (.) so (.) i think (0.5) you should (.) not try and (.) not feel so (.) sort of as you are because there really are things that can make it better for you [and that's definitely a positive outcome

Patient: [okay (.) ah right (.) well thank you

Student: °°so yeah try not to worry too much°° (.) and i understand that your father is a concern for you as well (.) is there anything else in your family history

Patient: um no not really (.) no

Student: good (.) umm so just to complete my history i'm going to ask you a few more uh general questions (.) so we've touched on the fact you've got IBS (.) do you have any other medical (.) problems

Patient: not really (.) no nothing i can think of

Student: okay (.) alright (.) okay (.) and um (.) social history you live with your partner

Patient: yup

Student: um do you have any children

Patient: yeah we've got a daughter (.) she's fifteen

Student: okay (.) and is she (.) a teenager or hhh.

Patient: she is yeah (.) fifteen yeah

Student: okay (0.5) brilliant (.) and (.) um you mentioned your job (.) is that going okay

Patient: yeah (.) oh yeah we've still got the contracts n yeah so it's going well (.) sort of

Student: good (.) and are you on any medication

Patient: no

Student: okay (.) alright well uh thank you very much for talking to me today and i wish you the best of luck

Transcription Example 3: PPIRes Focus Group Transcription

AM: So before we start, are there any comments or questions about the project?

P1: Often it's what is not said that is more to the point I find.

AM: Mhmm. So are you saying it's more to do with body language?

P1: Well it's body language and what is not said. You know um, I can give you an example. I had an emergency appointment at the hospital um and I went to go and I went in and the doctor didn't look at me. He just said 'name'. And it was not... you know if he'd said hello or I am. But I just feel myself withdrawing and I walked out. So it was what was not said then.

AM: That's a really good point in terms of what's not said and I think we'll be able to build on that today.

P2: It actually goes a bit further back than that because my wife has blood tests for regular bits and pieces in terms of the doctor's letter just said 'the doctor wants to see you' and we couldn't go for a week so you have a week thinking 'what is wrong'?

AM: Okay. So that's perhaps more on the administration side.

P2: Yes. But it's still linked in. Because you've got the tension before you get there.

AM: And would you say that that can affect the way you experience um or the rapport with the doctor to start off with.

P2: Yes because she was worried before she went in. And when she got in she was obviously terrified.

AM: Okay, any other questions or comments before we move on.

P3: I think for me it's that the doctor will listen. Um. I feel very comfortable when he says 'are there any questions'. But sometimes you don't know the question to ask, to get the answer you require. So I think, I like space to go back because then you can think about it and think oh why didn't I say that. But it's that space, yes.

AM: Okay so to start today, without talking to anyone else, can you just write down very briefly what you think empathy is.

panel members writing

AM: So do you want to read them out?

P2: Yeah to me it involves body language. The words used. Tone delivered in. Physical interaction from the doctor's face. Looking at the patient. Offering a chance for questions. Avoiding closed questioning or answering.

P1: Um. Mine was understanding patients and their feelings and having a connection.

P3: Ummm. An understanding of what is said and felt. Showing this understanding by words and gestures.

P4: Empathy is the feeling I've been understood; listened to, without judgment or without them being irritated by me. Which some doctors do you know?

AM: Okay so a couple of main things from that. Understanding was mentioned. What do you think that understanding relates to?

P2: I would say that if the doctor's actually read the patient's notes, he would have a little bit of understanding of how they were feeling. In-so-much as you know major events in their past. Then they might understand if they have anxiety or not.

AM: Mhmm, so you said felt there so would you say it's to do with emotions?

P2: Um. I just think that if they read the notes they would get a feeling for the patient. So it is emotions that make an understanding of the patient if they're very tense or etcetera etcetera.

P3: I think it is to do with emotions and I think that it is about being open and not having preconceived ideas.

P4: An example of that I was thinking of people who are very obese or have got a lump um I think that it would be quite easy for a doctor to be irritated by them but they really don't know what their life experiences or where they come from. And I think they've just got to be open and just sort of be a blank page for the patient to write on.

P1: He needs to appreciate he may well be dealing with this particular case five or six times a day. It's your first time. That's important.

AM: You also mentioned the words used.

P3: I often think there needs to be a clarification of words because if I say 'I'm angry, or anxious', or whatever the word you don't really *quite* understand. You understand it that angry might be terrible, but somehow in my book it means perhaps a bit irritated. So I think words can mislead sometimes.

P2: Not just the words but the tone the words are delivered in so they're not judgmental. Certainly shown with a smoker, who's got lung cancer. He can't say he's got lung cancer in a way that it's his fault.

AM: Okay, so that's more on the non-verbal. Did we also say body language?

P1: Yeah; eye contact is so important. I mean I know all this about health and hygiene, but you walk in and the doctor doesn't even look at you. I mean that's bad enough *and* shake your hand. So you know they can spray their hands afterwards if they want. But that's you know the initial meeting is so important because we make up our minds even though we don't know it but we make up our minds straight away.

AM: You mentioned the doctor not looking at you; what are your opinions on taking notes?

P1: You can take notes, but is there any reason why when I walk in you can't look at me and say 'hello, I'm doctor so-and-so', and then you can take notes. But it's the initial looking at you, and then you should then be able to read what's on my face, you know fear or whatever.

AM: And you said about shaking hands; would you always expect a handshake?

P1: Um, it's quite nice to have a handshake.

P2: I don't know if they need to take notes. I mean I go and visit my GP and he doesn't take notes when we're discussing the thing. He will talk about it and then he will take a few notes down. But he does look at you when he's talking to you.

P1: What about in a hospital; they don't take notes there.

P2: Yeah but you can be talking to the person and then you can state, 'I just need to write it down'. But when you're talking to them and when they're talking to you they should be looking up at you.

P1: But if you're going to say that it might break the flow of conversation.

P3: I think the introduction is more important for me than the handshake. I think to say, you know I'm doctor martin, I think particularly if you're going to examine me, I find that more important than shaking hands.

AM: Using the surname as well; is that important for you?

P3: Well because it's a more formal relationship isn't it?

P1: And sometimes you have other people in the room, and it's like 'who are you and why are you here'?

AM: Okay, and what would you (P4) say is the most important part?

P4: Well my own GP is absolutely smashing. When you go in he immediately excuses himself if he's kept you waiting, and then he turns around on his chair so you're facing him. And then he listens. And you come out of there, he may not have said anything at all to move the situation on, but you feel you've been heard. And that for me is important.

AM: When you say facing you, how is he sitting?

P4: *shows sitting at an angle, not directly facing* He will lighten things, you know, sometimes he'll say something that makes me laugh and you know that's really good because I feel relaxed. I don't feel worried when I go in to see him.

P2: At my practice, the doctor always comes to the door of the consulting room to meet every patient. It's not buzzers going. He comes to the doctor and calls you by name.

AM: So again that links to how the situation is set up, so would that fall into the empathetic side of things as well?

P2: I think it does because it sets the tone. He's trying to make you feel relaxed, comfortable, and encourage you to talk.

P3: In a hospital situation, if the doctor does show empathy, he gets more information from the patient. Whereas, if there's this barrier, I would go yes/no answers, and he was getting no information, and I just thought this is ridiculous. Whereas if he was nice, he could have got a lot of information in a short space of time.

AM: So I suppose that links with time as well.

P1: Yeah yeah, well we can give them little details that are so important. If you get a yes/no answer, you've got no information. I could mention something that was actually quite important inadvertently and they can pick up on that.

AM: *summarises discussion thus far* is there anything I've missed out or anything anyone would like to add?

P2: I think open questions, where's it's not just yes/no.

P3: And not coming from a preconceived idea, being more open to what might be communicated.

P1: But then you can ask questions and it can be a yes/no answer. Have you had this pain long? Yes. And I can leave it at that. Although I can say yes I've had it and it comes and goes. But then they'll say how long and I'll say three months. But then the real answer would be I've had it for a long time, but the last few months has been really bad.

AM: And what does P5 think?

P5: My description was ‘being able to put yourself in the position of another person, being able to appreciate the feelings...

P1: But how can you appreciate the feelings.

P5: Without being...

P1: No.

P5: Condescending.

P1: Yeah, but you don’t know how I’m feeling; you can’t imagine how I’m feeling.

P3: I think you can try actually.

P2: Only if they’d read my notes and know my background.

P3: My perception was you’ve got to try to... otherwise you won’t bother. I mean trying. You must be trying to know what the pain feels like for you.

P2: I think also every patient is different. I’m hot-headed and feisty. You know, and other people are calm and cool, so every patient’s different. So when you say ‘I understand how you feel’, you can’t.

P1: You can try to understand.

P2: But the doctor has to try to take on board every patient.

P4: I get the feeling now that years ago when I went the doctor was the professional, but now it’s a partnership.

P2: It is important that the doctor acts professionally. If you’re telling someone with cancer that they’ve got three months to live, it wouldn’t help me if the doctor then burst into tears. They’ve got to somehow remain a little detached and professional, but still be sympathetic and empathetic.

panel is introduced to, and watch, clip 010

P2: Um. I didn’t like her language. There were too many ums, yeahs, ahs.

P1: Yeah. Yeah.

P2: All the way through. She was... she said at a point she said thank you, which was good. When she was talking to him, she thanked him. Which I thought was good again with building rapport. The questions about haemorrhoids; did he understand or know anything about them, again is checking understanding. There was a good

discussion about haemorrhoids. Um she gave him the patient time to ask questions. Gave him time to talk about the father. So that is a combination of checking understanding and rapport, it could come under either.

AM: Yeah.

P2: Because then yeah. Clear explanation of haemorrhoids so that was checking understanding. And again I got too many ums, yeahs. She listened to the patient about the IBS. So that's checking understanding. Why not ask the medical history earlier, I wondered?

P3: I thought the IBS thing was a bit late. You know a bit fearful in the first stage and then she actually doesn't get to the IBS, when she's talking about the fibre, because he just throws it in, and I'd like to check what IBS was. You know, he might say he's got IBS, but...

P2: Well IBS is one of these wonderful things that covers all sorts of manifold sins. You can be going to the toilet all the time. You could be constipated all the time, and other problems. The thing that concerned me, she had quite a monotone.

P1: Every now and then she got bored. You could see she was bored. Her voice was *boring*. And that was annoying.

P2: So this thing about IBS is understanding. It's also rapport. Uhh, I don't know where you're going to put medical history should have come earlier. And rather monotone.

P1: And mumbling. She was mumbling.

P2: Yes. Yes she was.

AM: Okay. Thank you. P2?

P2: Um. Basiscally, um she was asking okay your age. I thought if she'd read his notes; that always annoys me. Okay I would say again blood vessels she was just boring me. It's boring boring. So she's really got to learn to keep her voice up to par.

AM: What about initially as well you said could I make her slow down.

P2: Yeah. Nu-nu-nu-nu. I didn't and a patient doesn't always hear. We pretend we do. But we don't hear. I know that sounds silly, but you can give us all the answers but it hasn't gone into our heads. Especially when it's a situation like that. Oh yeah and she was empathetic when it came to he was talking about worried about his father's cancer, and she said there are many other causes for bleeding. You know, she was good there.

AM: So what would that come under?

P1: Would it be rapport there? No that's not building a connection, is it?

P2: Reassurance. *long pause* Um. When we got to the bit when she was talking about I want to assure you that the problem is just treatable. Is she, she really getting very boring, and she didn't give him a chance to... I just felt like she should have been saying, you know if you are confirmed we can look further. She didn't give him... come on P1.

P1: Open ended questions. It was closed.

P2: It was closed.

P1: She was making statements. Yeah, that's what we're saying. Um. I don't think her reassurance was good, because I would have wanted to investigate further to really say no.

AM: mm

P1: It was all ums. The ums kept on coming in, and *well*. So she wasn't, that wasn't very good. Her voice towards the end was really you could hear it getting... so... boring.

AM: You keep saying her voice was boring. Does that relate to empathy in terms of...

P1: She wasn't in contact with the patient. It was like I'm just talking to the brick wall over there. You know and then when you're done you can have some treatment and then this happened, you know? Your voice can be your eyes as well as your ears.

P2: I mean I think there's a danger when some people speak, you switch off. I have a friend who's very turgid. Part way through whatever he says, my mind has switched off and I'm thinking about something else.

P1: I think she was losing the plot and she should have asked the patient a few more times, are you really happy with this, is there any... especially round the cancer area and his father because he was worried. Um. She didn't give enough reassurance. She didn't give enough information either. I don't think. Towards the end she was I understand you're worried etc etc. She was saying the right things, but again she was saying it, but she wasn't meaning it.

AM: So you didn't think that that was genuine.

P1: No I didn't. When she said don't worry, it'll be alright.

AM: Okay, is there anything else that you'd like to add?

P1: No, it's all here.

P3: Um. It says here checking that patient's comfort, and she sort of said that. But then umm, said yeah yeah. I mean I think she seemed to have asked most of the questions and some would lead on from there. They were the questions. Was she concerned about things, and was he concerned? Then, then it didn't go anywhere. I mean I

thought her body language looked okay. It was difficult to see her whole body, but she was looking formal and she nodded. I don't think she smiled.

P1: She was near the end.

P3: I can't remember. But that looked okay. But it was almost as if she was very playing the doctor, rather than the human. As somehow there was lots of explanation; lots of options for treatments, but not that human contact I thought.

P2: Her hands together. Body language was a bit distant I would have thought. Yes, I think you're a bit distant to the person; you're not actually being open to them.

P3: Um. Yes, the bleeding that was the back passage I mean she gave her bit about the blood, I would sort of more reiterate what P2 has said. Because she did try to make it specific. I thought there were lots and lots of explanations. She seemed to explain a great deal I think, because at one point she says do you know much about haemorrhoids? Then he says it's something to do with the blood vessels and then she took over. So there wasn't a getting it from him. What he knew about haemorrhoids, apart from it was to do with blood vessels.

AM: Yeah, so it's one thing asking what the patient knows, but then if you're not going to let them tell you what they know

P3: YEAH. Yeah. And how can you possibly be empathic. It's like was it just on the loo paper the blood or was he, or were there pints and pints I mean. And so therefore she didn't really get to know it, and I think didn't allow herself the opportunity to be empathic. Because she was sort of there. But not quite.

P1: And I also think that with the treatments she wasn't helping him. She was asking, what do you want? So, you know... poor patient.

P3: I think at the end when she said not to worry.

laughter from group

P3: Don't *ever* say that. You say don't worry and my god you're going to worry aren't you.

P1: And relax.

P3: And when doctors say it will be uncomfortable, not painful. One of your things is affecting the day-to-day, and she sort of got there, in the partner was moaning, there was a teenage daughter, he was finding it uncomfortable at work, but I don't know that he knew she'd shown that she understood about that.

AM: How would you have said that she could have shown that she understood?

P3: By saying you know it sounds like it's really affecting your life.

P1: Yeah. And giving him some advice.

P3: She did tell him to have more fibre or that would discord the IBS.

P2: Pillow. One of the rings. Haha.

P3: So I think she could have said it sounds like you're really very frightened, and it's painful and it's affecting your life.

P4: I just wonder, if she's trying to extract a history from him isn't she? What has been happening to him. But as I say, she did most of the talking. And I would question if she was actually telling him too much in a way. I felt that she should have extracted the information, let him talk more, but then he's telling her all these things and really he should go back to his doctor, not – you should eat more fibre. I mean he'll go away and think oh well as long as I eat more fibre and do this and this. And then when she says about his teenage daughter, is she a teenager, but she's already told her she's 15, so you're wondering if she's hearing what he's saying.

AM: You said about treatments options.

P4: Yes, she said do any of them sounds appealing – well no none of them sounds appealing.

laughter from group

P1: So again, it seems as though she was reading off of a card. You can have this, this, this. Which one do you want? Special offer on such and such. So it was information and she tried to make it sounds empathetic but it just came across as 'I'm getting bored now'.

P4: I think she was anxious to do it properly, so she was giving him too much information. Whereas she should have let him talk more, and then from what he was saying I definitely think you should go back to see your doctor. It changes, when he said my dad had bleeding from his back passage, and turned out he had bowel cancer... there, I think she went into overdrive really about what you could do and what you couldn't do, and really at that point, and with all the things that he's saying is wrong with him, I don't think she would be stepping over her remit to say I think you should definitely go back to your doctor, and explain what's been happening

P3: But she isn't a doctor, she is a student and she's just trying to get a history from him.

P1: She should have asked, did you tell your doctor this?

P4: Yes, yeah.

P1: She should have asked that question, you know – did you talk to your doctor about this? Because that again could mean she doesn't pass the information on, he thinks that she has and it could be missed out, and that could be a very dangerous situation.

P4: As a patient you imagine that they're all communicating with each other, but having been around a hospital.

P1: Not necessarily, no.

P4: But nobody knows even where your notes are. So that was a very big thing for her to pick up on.

P3: Coming back to this point about missed opportunities, where he said what was the blood like? Wonderful, open question, tell me what it is like. And he says it's red. And then she takes over, it was red.

P1: I would have thought she'd like to know a bit more about that. Red. Red. Hmm.

P3: But again it's as though she's trying to give a diagnosis, which isn't what she's there for. She's just trying to get some information.

AM: Mmm

P3: Do they have pressures with time? Because I'm just thinking, one of the things with saying tell me more, is I've got to get this done in time you know. And I think that's quite hard. So it's a very delicate balance isn't it? Between being empathic, and getting the job done.

AM: Yeah.

P3: I'm just wondering if at any time that patient knew that somehow he'd been heard. To be able to say it seems to be affecting your life. I don't know that she did that.

AM: Did anyone notice that?

P3: Yes, she does say is there anything that concerns you about the cancer, but I don't think there were any other.

P1: So what sort of empathetic patient do we think she was?

P4: I think she's trying to be there.

P1: She got bored at the end.

P3: Who keeps the time.

AM: I do. Usually 10 minutes.

P2: But at the same time if somebody needs 11 or 12, they've got to give them it. And they must realise that.

P3: There is a fear that they'll go on and on and on and on.

P2: I think if they just rambled, they can gently tidy it up. But it may well be that at 10 minutes they haven't told them the final most important bit. I'm worried about my father having had cancer. So you've got to be aware of the time, but you've also got to be flexible and just allow people that minute of two if they need it. The whole way through my surgery, there are notices *you have ten minutes time but if you need more, we'll give it to you.* To help patients understand.

P2: The other thing I felt was that, as she got more into the timing, she was adopting his manner of speech even more and more.

P1: Oh yes.

P2: Which as a patient, I might find slightly annoying.

AM: Oh really?

P3: Can you give an example P2?

P2: There'd be more um ahs yeahs.

P1: She must learn not to say 'yeah'.

P2: She is a professional. She speaks like a professional.

AM: So why would you say no to the yeah?

P1: It's just unprofessional. If she just said yeah to me I'd probably say yeah. You're the professional. I can say yeah at times, but you're the professional. Be the idol. The man. You know, all the time, I want to respect you, I need to respect you. Because you've got my life in your hands.

clip 003 viewed by panel

P4: His body position was good. He was leaning forward. He was listening, you got the feeling he was listening. He was listening to what she said to him.

AM: Was there anything in particular that made you think that he was listening?

P4: The way he had that sort of leaning, and he was closer, than with the other two. He was closer. And he kept checking with the patient – is this alright? And he also asked

how did it affect your life. And the only thing was I wondered when he said more invasive, wonder if a lot of the public wouldn't know what invasive surgery meant. He might have lost them there. I know a lot a lot of people do understand what it means but it is a medical sort of word, rather than just an ordinary word. But I thought it was very good.

P3: I was very worried that he ignored that fact that she seemed to not be able to sit on the chair. And I think that was so obvious and he did say are you okay?

AM: Mhmm.

P3: And she was so obviously not okay I would have liked a comment about that she was obviously in a great deal of discomfort. I thought that he said you're in good company. Twice. Which was the bit about haemorrhoids being common. And then there was a sort of reassurance there and he seemed to agree with that, that there was a diagnosis. And he said sure sure you really want to get it. And another empathic response I thought was good, he did say it does sound terrible but it's not supposed to be painful. And the response was that she wanted them gone for good which I think he understood, that she needed to have them done and gone for good as it were. And I thought he warmed up; I thought he was quite hesitant in the beginning and I thought *please* say something about her being so uncomfortable, but he then sort of warmed up and I agree with P4: posture was much more accepting somehow.

AM: Thank you very much.

P1: Okay. I found in the beginning he had no connection with the patient. Um he introduced himself, but he didn't know her name. Which I thought was quite rude, again as I said, read notes etc. That was um bad. The beginning I thought he had no interest. Yes my niece is at medical school. Oh how nice you know what year is she or something.

AM: Mhmm.

P1: But he made no connection, no nothing. Um, further on he got really good, but the initial building of the confidence of the patient, doctor-patient let him down. Okay he seemed not interested in patient and yeah no connection with the patient further on. Um, good body language leaning towards, so in some ways his mouth wasn't saying what his body was saying. At one point, I didn't think he had much confidence, and I think that was the bit when it was the social chat. Once he got into the diagnosis and this is the treatments, he has confidence. But prior to that he didn't have confidence. He did explain the treatment, but I don't think he found out if she had any other worries I think. And again, some of his language 'sure sure', it's okay, but... And I think somewhere along the line he said have you got any but I think at the end he should have said is there anything else?

AM: Thank you very much.

P2: I think like most people he started off slowly. And he got better as he went along. I didn't like him interrupting the patient when she said about her niece being a medical student. Some doctors get very touchy when you use self-diagnosis. So not keen on that. Didn't like some of his language. Sure. Sure. He was going on about out-patients. The leaning forward I thought was good. And he was talking with his arms as well which I think is nice. He was also concerned about her comfort; he asked she was obviously sitting awkwardly – he was concerned about that. Was she okay. I wasn't actually convinced that he really knew what haemorrhoids are.

AM: Okay

P1: Yeah, there's a lining of the thing.

P2: Yes. It was somewhere in there, I wasn't sure. She self-diagnosed herself I felt, and he didn't then say have you discussed all this with the doctor? It's the IBS self-diagnosis. She said I've got IBS; he should have said have you discussed this with your doctor? I felt he was trying to be empathetic, explained technical terms but then he lost himself about the injections, he's got to explain that a little more clearly what the injections meant. He offers more information which was good. I immediately ran for the hills when he said we're running out of time.

P1: You don't tell a patient that.

P2: Don't say that to me. That really to me is a big NO.

AM: Right.

P2: I felt he appeared more interested and more positive as he went through. He seemed to get more comfortable with her. Or he likes the diagnosis, he likes talking about treatment, rather than the person.

AM: So as a group, which of the consultations we've seen today which would say is the more empathetic?

P4: Second one *echoed by group*

P1: Yeah maybe, but that start may have put me off, and I would have gone to my defensive mode.

P3: And did either say thank you very much at the end?

P2: She did.

AM: And would you say that's empathetic then?

P2: It's courteous, it's polite. It's mutual respect.

Forms and Recruitment

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Dear Student,

I should like to offer you the opportunity to participate in a research project here at The University of East Anglia. The study is an investigation into expressions of empathy within medical consultations, and will be structured similarly to the consultation skills sessions you have been attending in your PBL groups. Between twenty to thirty volunteers are required to partake in simulated role-plays with professional actors from the Simpatico Company, with each role-play consisting of a consultation between a student and simulated patient.

The study should take around an hour of your time, and would greatly assist with the development of both the training and recruitment of future medical students at the UEA. You would be given a copy of the recording as something to assist with your training, or potentially show future employers. In addition to this, your participation would be something you could list on your curriculum vitae, as well as on the Medical Training Application Service. Note that a full debriefing will be offered by one of the consultation skills tutors if required.

A better understanding of the concept of empathy is becoming a necessary concern in healthcare, and to have participated in such a study may also aid in your practice and future employment. If this is something that appeals to you, or you would like further information, please do not hesitate to contact me; email A.Marsden@uea.ac.uk, telephone +44 (0) 1603 593094, or come and see me in person in the Queen's building, room 0.27.

Thank you for your time, and I look forward to hearing from you,

Yours faithfully,
Alex Marsden

Student Participant Information

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Background Information

The concept of empathy is fast becoming an integral part of undergraduate medical education. Whilst there have been numerous studies conducted around the concept, very little work takes into account exactly how empathy is realized in communication. This study aims to examine this link, and use the results to help improve the consultation skills and recruitment process for the MB/BS degree programme here at the University of East Anglia (UEA).

Why are you being invited to take part?

All students in the fourth year of the MB/BS programme at the UEA are invited to participate in this research. This is because your training to date means that you should be able to conduct a simulated consultation based on the Calgary-Cambridge model. Note that if a large number of students volunteer, not all will be able to take part.

How will the simulated consultations work?

Once you have formally consented to participate in the research and had the opportunity to ask the researcher (Alex Marsden – Postgraduate Researcher) any questions you may have, you will be asked to conduct a simulated consultation similar to one you would carry out in the Consultation Skills module. This will be done with an actor from the Simpatico Role-play Agency, who will also have worked on the Consultation Skills module here at the UEA, and will be recorded on video. Once your consultation is complete, you will be asked to watch the recording and identify where you think certain communicative features were present or absent.

Do I have to take part?

No. Participation is entirely on a voluntary basis, and you should know that choosing not to participate will have no impact on your future studies or examinations here at the University of East Anglia.

What are the benefits of this research?

The development of the concept of empathy is becoming a fundamental aspect in healthcare, and to have participated in such a study may aid in practice and future employment. It is something that could be referenced on both your curriculum vitae and the MTAS and you would also be helping to improve the teaching methods on the Consultation Skills module and the recruitment process for the MB/BS course. Moreover, a full debriefing from a trained consultation skills tutor will be offered at the end of the consultation if needed.

What are the risks of this research?

The level of risk to participants is relatively low. Given that the study deals with empathy, there are potential elements involved in the scenarios that may be difficult emotionally; however, the scenario used is part of the Consultation Skills module at UEA, and therefore, you should be familiar with it from your previous studies. The consultation and feedback should take around an hour of your time.

Student Participant Information

WORKING TITLE: Empathy in Undergraduate Medical Education

CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Will anyone else see or hear the recording of my consultation?

Yes. In order to analyse the data accurately, the recording will be used by the researcher (Alex Marsden – Postgraduate Researcher), in addition to his Ph.D supervisory panel, who are a group of five UEA Faculty of Health staff specialising in language and empathy, as well as the Patient and Public Involvement in Research (PPIRes): volunteer members of the public who assist researchers by giving a patient's perspective on their studies. In addition, you will be given your own personal recording of the consultation, which you may show to anyone you wish. You may opt to permit the use of the data for teaching purposes and in presentations, although this is not essential to you taking part in the project.

How will the data be used?

The data is set to be used in a Ph.D thesis. The data will be analysed with regard to the comments you make about the communicative features, as well as the actor, researcher, panel, and PPIRes identifying key communicative features in the recordings. The findings may be published in journals, although the participants will remain anonymous. Moreover, the results will be complied into a report with suggestions on how to improve various aspects of the MB/BS programme.

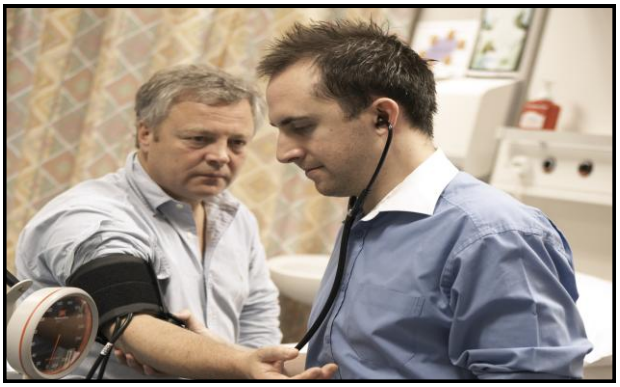
If you would like to participate in this research, please contact Alex Marsden at

A.Marsden@uea.ac.uk, phone 01603 593094, or get details in the Queen's Building 0.27.

FORM 1C

What is Empathy?

University of East Anglia



An increased understanding of the concept of empathy is fast becoming an integral part of undergraduate medical education. This is your chance to help develop the communication skills training programme here at the University of East Anglia.

WILL YOU BE A FOURTH YEAR MEDICAL STUDENT IN OCTOBER 2010?

Starting October 2010, research will be conducted in the UEA MED School on how empathy is expressed through the use of language and gesture. If you will be a fourth year medical student at this time, and would like to participate, please contact Alex Marsden at A.Marsden@uea.ac.uk, phone 01603 593094, or get details in the Queen's Building 0.27.

'Conversation strengthens empathy. In the end, empathy is a two-way street […] and it is needed as much today as ever before'.
Howard Spiro, Professor of Medicine, Yale University School of Medicine

'Communication skills are fundamental to the practice of medicine'.
Jonathan Silverman, Associate Clinical Dean, University of Cambridge School of Medicine

'Few scholars would disagree that empathy is the overarching skill that is at the heart of caring. But, exactly what empathy is and how it works is still a subject of much debate'.
Richard Frankel, Professor of Medicine, Indiana School of Medicine

Student Consent Form

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Please initial each box

1. I confirm that I have read and fully understand the information sheet provided for details about the project.	
2. I confirm that I have had the opportunity to ask the researcher (Alex Marsden – Postgraduate researcher) any additional questions I have about the project.	
3. I understand that my personal details (e.g., name, age) will be strictly confidential and stored securely at the University of East Anglia.	
4. I agree to my consultation being video recorded and observed by the researcher (Alex Marsden).	
5. I understand that the data gained from this research will be shared with the supervisory panel and members of the Patient and Public Involvement in Research group (PPIRes).	
6. I agree to anonymised written transcripts from my recorded consultation being used for the purposes of the research including report writing, publication and presentations	
7. I agree to short audio-visual transcripts from my recorded consultation being used for the purposes of the research, report writing and publication. All names and identifiers will be removed. **If you do not wish for your simulated consultation to be used in this manner, or are unsure at this point, then please leave this box blank.**	
8. I agree to short audio-visual transcripts from my recorded consultation being used for the purposes of the teaching and training in healthcare and academic settings. All names and identifiers will be removed. **If you do not wish for your simulated consultation to be used in this manner, or are unsure at this point, then please leave this box blank.**	
9. I understand that the interviews will be video recorded, and the data file will be stored on a secure computer at the University of East Anglia.	
10. I understand that my participation in one simulated consultation and one feedback session is voluntary, and I am able to withdraw from these, and withdraw any data collected, without giving a reason.	
11. I understand that my participation, or non-participation, in this study will not affect the level of teaching or examination I receive from the University of East Anglia.	
12. I agree to participate in this research project.	

Researcher:		***Participant:***	
Name:	_____	Name:	_____
Signature:	_____	Signature:	_____
Date:	_____	Date:	_____

Baseline Data

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Thank you for agreeing to participate in this research project. Please take a moment to complete the following form concerning your background details. Note that this information will only be known to the researcher (Alex Marsden – Postgraduate Researcher), and will not be shared with any third parties. It is merely intended to assist with the analysis.

Participant Number (for researcher use only): _____

Please tick ☑ the following boxes for the categories which best apply to you:

Gender: Male ☐ Female ☐

Age: 18-21 ☐ 22-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 70+ ☐

In your last OCSE, which quartile did you come under ?

A ☐ B ☐ C ☐ D ☐ Prefer not to disclose ☐

What was your role before becoming an MB/BS student (e.g., school leaver; previous degree)?

_____

What nationality would you describe yourself as?

_____

What ethnic background would you describe yourself as belonging to?

_____

How long have you lived in the United Kingdom? Have you ever lived anywhere else? Please give details.

_____

What is your first language? Do you speak any other languages? If so, please give details.

_____

Actor Participant Information

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Background Information

This project involves a study of how empathy is used by undergraduate medical students in simulated consultations. The concept of empathy is fast becoming an integral part of undergraduate medical education. Whilst there have been numerous studies conducted around the concept, very little work takes into account exactly how empathy is realized in communication. This study aims to examine this link, and use the results to help improve the consultation skills and recruitment process for the MB/BS degree programme here at the University of East Anglia.

Why are you being invited to take part?

The Simpatico Role-play Agency has been working in conjunction with the University of East Anglia's Consultation Skills Tutors for more than eight years now, helping to train the students with their communication skills. Therefore, their actors are experienced in this type of scenario, and this should help in gaining the most accurate and reliable data for the study.

How will the simulated consultations work?

Once you have consented to participate in the research and had the opportunity to ask the researcher (Alex Marsden – Postgraduate Researcher) any questions you may have, you will be asked to read a role-play card, similar to the ones you would use in the Consultation Skills module. This will give a scenario, for which the student will conduct a simulated consultation with you. Once your consultation is complete, you will be asked to watch the recording and identify where you think empathy was either present or absent in the simulated consultation.

What are the benefits of this research?

The concept of empathy is becoming a fundamental aspect in healthcare, with the ultimate aim of this study being to augment the Consultation Skills module with scenarios that will allow for students to express empathy to a greater extent. Moreover, this data will also be used to aid with the recruitment process at the University of East Anglia, particularly with regard to the interview process.

What are the risks of this research?

The level of risk to participants is relatively low. Given that the study deals with empathy, there are potential elements involved in the scenarios that may be difficult emotionally; however, the scenario used is part of the Consultation Skills module at UEA, and therefore, you should be familiar with it from your previous involvement in the Consultation Skills module. Each consultation and feedback should take around an hour of your time, and you will be paid for your participation.

Actor Participant Information

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Will anyone else see or hear the recording of the consultation?

Yes. In order to analyse the data accurately, the recording will be used by the researcher (Alex Marsden – Postgraduate Researcher), in addition to his Ph.D supervisory panel, who are a group of five UEA Faculty of Health staff specialising in language and empathy, as well as the Patient and Public Involvement in Research (PPIRes): volunteer members of the public who assist researchers by giving a patient's perspective on their studies. In addition, the students will be given their own personal recording of the consultation, which they may choose to show to future employers, or use to aid their training.

How will the data be used?

The data is set to be used in a Ph.D thesis. The data will be analysed with regard to the comments you make about the communicative features, as well as the student, researcher, panel, and PPIRes identifying key communicative features in the recordings. The findings may be published in journals, although the participants will remain anonymous. Moreover, the results will be complied into a report with suggestions on how to improve various aspects of the MB/BS programme.

If you would like more information on this research, please contact Alex Marsden at

A.Marsden@uea.ac.uk, phone 01603 593094, or get details in the Queen's Building 0.27.

Actor Consent Form

WORKING TITLE: Empathy in Undergraduate Medical Education

CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Please initial each box

1. I confirm that I have read and fully understand the information sheet provided for details about the project.	
2. I confirm that I have had the opportunity to ask the researcher (Alex Marsden – Postgraduate researcher) any additional questions I have about the project.	
3. I understand that my personal details (e.g., name, age) will be strictly confidential and stored securely at the University of East Anglia.	
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8. I agree to short audio-visual transcripts from my recorded consultation being used for the purposes of the teaching and training in healthcare and academic settings. All names and identifiers will be removed.	
9. I understand that the interviews will be video recorded, and the data file will be stored on a secure computer at the University of East Anglia.	
10. I understand that everything that happens in the simulated consultation and feedback is confidential, and that I am not to share any information about this with anyone other than the researcher and the student.	
11. I agree to participate in this research project.	

Researcher:		***Participant:***	
Name:	_____	Name:	_____
Signature:	_____	Signature:	_____
Date:	_____	Date:	_____

Role-play Scenario

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Note that this scenario has been taken from the Consultation Skills module on Information Giving, Shared Decision Making and Planning: Year 3, Session 2, Scenario 8.3. Thanks goes to the consultation skills team for allowing the use of this scenario in the research project.

Name: Jamie/Janice Saunders **Age:** 42 (can be changed if necessary)

Setting
You are waiting in the waiting room at your GP surgery. Six months ago you visited you GP because you had noticed some bleeding from your back passage that comes on when you open your bowels. Dr Martin made a provisional diagnosis of haemorrhoids (piles) and referred you to the Colorectal Clinic at the N&NUH. The consultant confirmed it is Grade 2 haemorrhoids. You are now waiting to discuss the consultant's diagnosis with your GP, and, in particular, discuss treatment options. Dr Martin has asked you if you would agree to be interviewed by a third year medical student who has recently been learning about the diagnosis and treatment of haemorrhoids. You are happy to do this as your niece is a first medical student in Durham and you know how much she says she gains from talking to patients.

Clinical details
You have suffered with irritable bowel syndrome (IBS) for over two decades on and off and have noticed that at times your back passage is very painful and even protruding during and after opening your bowels. The IBS is intermittent, but when it is bad it gives you alternating diarrhoea and constipation as well as stomach cramps and wind. Your back passage is very uncomfortable and makes your day job difficult, as it is very sedentary. You have started sitting on a special circular cushion to relieve the pressure. You suspected it was piles, but were a bit embarrassed and unimpressed with the idea that this was serious enough to consult the doctor about. However, in the last six months the pain has been excruciating and you find there is always a small to medium amount of bright red blood on the toilet paper, but not in the stool itself. The area can be quite itchy. At the Colorectal Clinic you had a sigmoidoscopy. Previously your GP had simply done a digital examination. You found both very uncomfortable and undignified but want it sorted out, and therefore are prepared to put up with the indignity and discomfort.

Past medical history
You have had no previous operations and the only illness is IBS which you self-diagnosed about eight years ago when there was a lot in the press about it.

Medication
At one point your doctor prescribed Fybogel to keep you more regular and comfortable when emptying your bowels. You now use similar medication purchased over the counter for when IBS gets bad.

Smoking history
10-12 cigarettes a day

Diet
You are vegetarian, although you do eat fish.

Drinking
1-2 glasses of wine with your evening meal.

Family history
Your father had rectal bleeding in his late 60s and was found to have bowel cancer. He had a colostomy operation, but died 18 months later.

Social History
You live with your partner and together you run a small binding and printing company. You get some contracts from the university and from individuals.
You have one daughter who is 15 years old and fairly independent. You walk regularly and have always been very lean. You like your job and mainly run it from a large garden room at the end of the garden. You have one part-time employee.

Temperament
You do find life generally quite stressful, and are quite a highly strung person. You can get quite down and blue especially in the winter. You practice meditation and attend a local Buddhist centre on a regular basis to help provide some inner calm. You did not like turning 40 and do not like to admit to your problem with your suspected piles.

Patient's framework

- **Ideas:**

Now that the pain has become so bad and so regular, and the blood is so obvious every time you open your bowels, you are a little worried. You had wondered for a while about whether bowel cancer was in any sense hereditary. You have been looking various things up on the internet and getting even more anxious.

- **Concerns**

You will admit that you have been concerned that it could be bowel cancer if you are given the chance to talk about your worries.
You are not sure your partner will be very sympathetic and you feel that he/she sometimes sees you as a bit of a hypochondriac because of your on-going IBS symptoms.

- **Expectations**

You want to know:

- what haemorrhoids are and how they can be so painful (the consultant at the hospital was a man of few words).
- how you have got them and can prevent them in the future.
- what the treatment options are and the pros and cons of these.

- how soon you can be rid of this discomfort and would be interested in the most radical intervention (even though you are a little nervous of surgical interventions of any sort) if it can guarantee it will work and you will be able to sit and do your work in comfort again.

Feelings
You feel very embarrassed about the whole thing.

Effects on life
Your back passage is very uncomfortable and makes your day job difficult as it is very sedentary. You have started sitting on a special circular cushion to relieve the pressure.

Behaviour:
You don't mind talking to the student, but still get a bit embarrassed when talking about your discomfort in your backside.
You are keen to learn more about haemorrhoids and will respond well to the student's information giving. When invited, you will ask further questions about the various treatment options.
You will only reveal your real concerns about cancer and the worry about being a hypochondriac if the student makes a good effort at exploring your deep down concerns. The student may reassure you that the doctor would have checked for cancer during the sigmoidoscopy and with this information you will be able to come to a shared decision regarding the best treatment option for your haemorrhoids.

The aim of this scenario is for the medical student to gather information about the problems you are experiencing with your haemorrhoids and conduct a patient centred interview. The student needs to listen to your concerns and help you to understand the possible treatment options. In addition the student needs to explore any life style changes that may help the problem. We are looking to see if the student can present the options in an unbiased way, can involve you in decision-making and can really discover your views of what would worry you.

We are hoping that the student can use a collaborative process and enable you to make an informed decision. What might happen though if you do not get a chance to share your concerns fully is that you say to the student that you are quite unsure about the whole thing and really just want an operation to remove the haemorrhoids for good.

Role-play Scenario

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Note that this scenario has been taken from the Consultation Skills module on Information Giving, Shared Decision Making and Planning: Year 3, Session 2, Scenario 8.3. Thanks goes to the consultation skills team for allowing the use of this scenario in the research project.

Instructions for Students

You are a third year medical student on your primary care placement.

Jack/Jackie Saunders is 42 years old and, together with his/her partner, runs a small printing and binding business from home. He/she has been an IBS sufferer since his/her twenties and more recently has experienced acute pain and discomfort both during, and after, a bowel movement, and on sitting for prolonged periods of time. He/she has noticed fresh bright red blood on the toilet paper on a persistent basis and palpable lumps that protrude around the anus.

He/she is waiting to hear more about his/her condition, which is reasonably severe and to discuss treatment options with the GP, Dr Martin. He/she was recently referred to the Colorectal Clinic where after detailed examination including a sigmoidoscopy, he/she had suspected haemorrhoids confirmed.

Although not overly keen on surgical intervention Mr/Mrs Saunders is very keen to get the condition under control and preferably cleared up for good. The GP, Dr Martin has gained permission from Mr/Mrs Saunders for you to practice explaining some of the key implications of his/her grade 2 haemorrhoids and the main treatment options.

Background Information

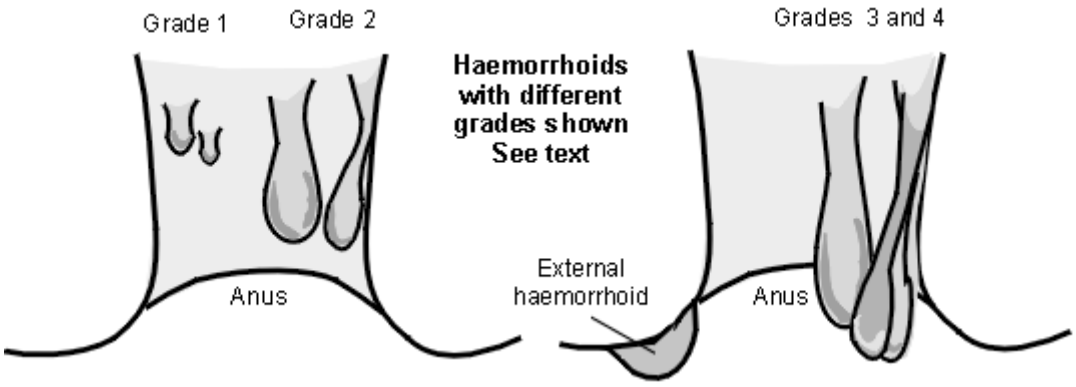
Haemorrhoids (Piles)
are swellings of the lining of the anus and lower rectum. Symptoms range from temporary and mild, to persistent and painful. Treatment is usually effective.

What causes haemorrhoids?
There is a network of small veins (blood vessels) in the lining of the back passage (anus and lower rectum). It is thought that these veins become wider and swollen with blood if the pressure in and around them is increased. The veins and the overlying tissue may then form into one or more small swellings called haemorrhoids.

About half the people in the UK develop one or more haemorrhoids at some stage. Many develop for no apparent reason. Certain situations increase the risk of them developing.
A common reason for haemorrhoids to develop is because of constipation, passing large stools (faeces), and straining at the toilet. These increase the pressure around the veins in the back passage.
Haemorrhoids are common during pregnancy due to pressure effects of the baby, and the hormone effects on the veins.

What are the symptoms of haemorrhoids?

Internal haemorrhoids
These form in the back passage about 2-4 cm above the rim (opening) of the anus. Their severity and size are classified into grades 1 to 4.



- **Grade 1** are small swellings on the inside lining of the back passage. They cannot be seen or felt from outside the anus. Grade 1 haemorrhoids are common. In some people they enlarge further to grade 2 or more.
- **Grade 2** are larger. They may be partly pushed out (prolapse) from the anus when you go to the toilet, but quickly 'spring back' inside again.
- **Grade 3** hang out (prolapse) from the anus. You may feel one or more as small, soft lumps that hang from the anus. However, you can push them back inside the anus with a finger.
- **Grade 4** permanently hang down from within the anus, and you cannot push them back inside. They sometimes become quite large.

Symptoms can vary. Small haemorrhoids are usually painless. The most common symptom is bleeding after going to the toilet. Larger haemorrhoids may cause a mucus discharge, some pain, irritation, and itch. The discharge may irritate the skin around the anus. You may have a sense of fullness in the anus, or a feeling of not fully emptying your rectum when you go to the toilet.

A possible complication of haemorrhoids that hang down (grade 3-4) is a blood clot (thrombosis) which can form within the haemorrhoid. This is uncommon, but causes intense pain if it occurs.

External haemorrhoid (sometimes called a perianal haematoma)
This is less common than internal haemorrhoids. An external haemorrhoid is a small lump that develops on the outside edge of the anus. Many do not cause symptoms. However if a blood clot forms in the haemorrhoid ('thrombosed external haemorrhoid') it can suddenly become very painful and need urgent treatment. The pain due to a thrombosed external haemorrhoid usually peaks after 48-72 hours, and then gradually goes away over 7-10 days. A thrombosed external haemorrhoid may bleed a little for a few days. It then gradually shrinks to become a small skin-tag.
Some people have internal and external haemorrhoids at the same time.

What is the treatment for haemorrhoids?

Avoid constipation and straining at the toilet
Keep the faeces (sometimes called stools or motions) soft, and don't strain on the toilet. You can do this by the following:

- **Eat plenty of fibre** by eating plenty of fruit, vegetables, cereals, wholemeal bread, etc.
- **Have lots to drink.** Adults should aim to drink at least two litres (10-12 cups) per day. You will pass much of the fluid as urine, but some is passed out in the gut and softens faeces. Most sorts of drink will do, but alcoholic drinks can be dehydrating and may not be so good.
- **Fibre supplements.** If a high fibre diet is not helping, you can take bran, or other fibre supplements ('bulking agents') such as ispaghula, methylcellulose, or sterculia. You can buy these at pharmacies or get them on prescription. Methylcellulose also helps to soften faeces directly which makes them easier to pass.
- **Avoid painkillers that contain codeine** such as co-codamol, as they are a common cause of constipation.
- **Toileting.** Go to the toilet as soon as possible after feeling the need. Some people suppress this feeling and plan to go to the toilet later. This may result in bigger and harder faeces forming which are then more difficult to pass. Do not strain on the toilet. Haemorrhoids may cause a feeling of 'fullness' in the rectum and it is tempting to strain at the end to try and empty the rectum further. Resist this. Do not spend too long on the toilet which may encourage you to strain. (For example, do not read whilst on the toilet.)
-

The above measures will often ease symptoms such as bleeding and discomfort. It may be all that you need to treat small and non-prolapsing haemorrhoids (grade 1).

Ointments, creams, and suppositories
Various preparations and brands are commonly used. They do not 'cure' haemorrhoids. However, they may ease symptoms such as discomfort and itch.

- A bland cream, ointment, or suppository may ease discomfort. They can be used as often as you like. Several brands are available without a prescription. Ask a pharmacist for advice.
- One that contains an anaesthetic may ease pain better. You should only use one of these for short periods at a time (5-7 days). If you use it for longer, the anaesthetic may irritate or sensitise the skin around the anus. A pharmacist can advise.
- One that contains a steroid may be prescribed by a doctor if there is a lot of inflammation around the haemorrhoids. Steroids reduce inflammation and may help to reduce any swelling around a haemorrhoid. This may help to ease itch and pain. You should not normally use these for longer than one week at a time.

Very painful prolapsed haemorrhoids are uncommon. The pain may be eased by an ice pack pressed on for 15-30 minutes. Strong painkillers may be needed.

Haemorrhoids of pregnancy usually settle after the birth of the child. Treatment is similar to the above.

Treatment options usually done as an outpatient.

- Injection of a 'sclerosing' chemical into the haemorrhoid.
- Banding using a rubber band which is placed at the base of the haemorrhoid. This cuts off the blood supply to the haemorrhoid which then 'dies' and drops off after a few days,
- Freezing of the haemorrhoid, and photocoagulation are other alternatives

An operation to cut away the haemorrhoid(s) is an option to treat grade 4 haemorrhoids, and for grade 2 and 3 haemorrhoids not successfully treated by banding or other methods. This is done under general anaesthetic and is usually successful.

Empathy Record Sheet

WORKING TITLE: Empathy in Undergraduate Medical Education
CONTACT: Alex Marsden • A.Marsden@uea.ac.uk • 01603 593094 • Queen's Building 0.27

Please review the consultation, and note down where you believe empathy is being expressed. Please describe the sections where this happens, and the time of occurrence (the time will be present on the screen).

Time	What happens?

(Copies for participants continued for three pages).

Bibliography

ANFOSSI, M. & NUMICO, G. 2004. Empathy in the doctor-patient relationship. *Journal of Clinical Oncology,* 22**,** 2258-9.

ARZY, S., THUT, G., MOHR, C., MICHEL, C. M. & BLANKE, O. 2006. Neural Basis of Embodiment: Distinct Contributions of Temporoparietal Junction and Extrastriate Body Area. *J. Neurosci.,* 26**,** 8074-8081.

AUSTIN, E. J., EVANS, P., MAGNUS, B. & O'HANLON, K. 2007. A preliminary study of empathy, emotional intelligence and examination performance in MBChB students. *Medical Education,* 41**,** 684-689.

AUSTIN, J. L. 1962. *How to do things with words,* London, Oxford University Press.

BACHELOR, A. 1988. How Clients Perceive Therapist empathy: A Content Analysis of 'Received' Empathy. *Psychotherapy: Research, Practice, Training,* 25**,** 227-240.

BAKER, C., WUEST, J. & STERN, P. 1992. Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing,* 17**,** 1355-1360.

BARON-COHEN, S. 2003. *The Essential Difference,* New York, Basic Books.

BARRETT-LENNARD, G. T. 1962. Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs: General and Applied,* 76**,** 1-36.

BARRETT-LENNARD, G. T. 1976. Empathy in human relationships: Significance, nature and measurement. *Australian Psychologist,* 11**,** 173-184.

BARRY, C. A., BRADLEY, C. P., BRITTEN, N., STEVENSON, F. A. & BARBER, N. 2000. Patients' unvoiced agendas in general practice consultations: qualitative study. *BMJ,* 320**,** 1246-1250.

BATSON, D. C. 2009. *The Social Neuroscience of Empathy,* Massachusetts, MIT Press.

BELLINI, L. M., BAIME, M. & SHEA, J. A. 2002. Variation of Mood and Empathy During Internship. *JAMA: The Journal of the American Medical Association,* 287**,** 3143-3146.

BELLINI, L. M. & SHEA, J. A. 2005. Mood Change and Empathy Decline Persist during Three Years of Internal Medicine Training. *Academic Medicine,* 80**,** 164-167.

BENNETT, M. J. 1979. Overcoming the golden rule: Sympathy and Empathy. *In:* NIMMO, D. (ed.) *Communication Yearbook 3.* New Brunswick: International Communication Association (Transaction Publishers).

BIKKER, A. P., MERCER, S. W. & REILLEY, D. 2005. A Pilot Prospective Study on the Consultation and Relational Empathy, Patient Enablement, and Health Changes over 12 Months in Patients Going to the Glasgow Homoeopathic Hospital. *Journal of Alternative and Complementary Medicine,* 11**,** 591-600.

BIRHANU, Z., ASSEFA, T., WOLDIE, M. & MORANKAR, S. 2012. Predictors of perceived empathy among patients visiting primary health-care centers in central Ethiopia. *International Journal for Quality in Health Care*.

BMJ 1996. Complementary Medicine is Booming Worldwide [News Item]. *BMJ,* 313**,** 131-133.

BRANCH, W. T. & MALIK, T. K. 1993. Using 'Windows of Opportunities' in Brief Interviews to Understand Patients' Concerns. *JAMA: The Journal of the American Medical Association,* 269**,** 1667-1668.

BROWN, P. & LEVINSON, S. 1987. *Politeness: Some Unviersals in Language Usage,* Cambridge, Cambridge University Press.

BRUCE, S. 2004. An Analysis of Communicative Functions of Teachers and Their Students Who Are Congenitally Deafblind. [References]. *RE:view: Rehabilitation and Education for Blindness and Visual Impairment,* 36**,** 81-90.

BRYMAN, A. 2008. *Social Research Methods,* Oxford, Oxford University Press.

BURR, V. 1995. *Social Constructionism,* New York and London, Routledge.

BYLUND, C. L. & MAKOUL, G. 2002. Empathic communication and gender in the physician–patient encounter. *Patient Education and Counseling,* 48**,** 207-216.

BYRNE, P. S. & LONG, B. E. L. 1976. *Doctors Talking to Patients,* London, HMSO.

CAMERON, D. 2000. Styling the Worker: Gender and the Communication of Language in the Globalized Service Economy. *In:* JAWORSKI, A. &

COUPLAND, N. (eds.) *The Discourse Reader.* 2nd ed. Abingdon: Routledge.

CAMPION, P. & LANGDON, M. 2004. Achieving multiple topic shifts in primary care medical consultations: a conversation analysis study in UK general practice. *Sociology of Health & Illness,* 26**,** 81-101.

CAPE, J. 2002. Consultation length, patient-estimated consultation length, and satisfaction with the consultation. *British Journal of General Practice,* 52**,** 1004-1006.

CARKHUFF, R. R. 1969. *Helping and human relations: a primer for lay and professional helpers,* New York, Rinehart and Winston.

CARPENTER, L. & MERKEL, W. 1988. The effects of three methods of observation on couples in interactional research. *American Journal of Family Therapy,* 16**,** 144-157.

CATALDO, K. P., PEEDEN, K., GEESEY, M. E. & DICKERSON, L. 2005. Association Between Balint Training and Physician Empathy and Work Satisfactio. *Family Medicine,* 37**,** 328-331.

CENTER FOR DISEASE CONTROL AND PREVENTION. 2009. *Chronic Diseases: The Power to Prevent, The Call to Control* [Online]. Center for Disease Control and Prevention. Available: http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm [Accessed 23/10 2012].

CHARMAZ, K. 2004. Grounded Theory. *In:* NAGY HESSE-BIBER, S. & LEAVY, P. (eds.) *Approaches to Qualitative Research: A Reader on Theory and Practice.* New York: Oxford University Press.

CHARMAZ, K. 2006. *Constructing grounded theory,* London, Sage.

CHEN, D., LEW, R., HERSHMAN, W. & ORLANDER, J. 2007. A Cross-sectional Measurement of Medical Student Empathy. *Journal of General Internal Medicine,* 22**,** 1434-1438.

CHEN, D. C. R., KIRSHENBAUM, D. S., YAN, J., KIRSHENBAUM, E. & ASELTINE, R. H. 2012. Characterizing changes in student empathy throughout medical school. *Medical Teacher,* 34**,** 305-311.

CHOMSKY, N. 1965. *Aspects of the Theory of Syntax,* The Hague, Mouton.

COLEMAN, T. 2000. Using video-recorded consultations for research in primary care: advantages and limitations. *Family Practice,* 17**,** 422-427.

COMAN, G. J., EVANS, B. J. & STANLEY, R. O. 1988. Scores on the Interpersonal Reactivity Index: A sample of Australian medical students. *Psychological Reports,* 62**,** 943-945.

CORBETTA, P. 2003. *Social Research: Theory, Methods and Techniques,* California, Sage.

CORBIN, J. M. & STRAUSS, A. 1990. Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology,* 13**,** 3-21.

CORDELLA, M. & MUSGRAVE, S. 2009. Oral communication skills of international medical graduates: assessing empathy in discourse. *Communication & Medicine,* 6**,** 129-42.

COULEHAN, J. L., PLATT, F. W., EGENER, B., FRANKEL, R., LIN, C.-T., LOWN, B. & SALAZAR, W. H. 2001. "Let Me See If I Have This Right": Words That Help Build Empathy. *Annals of Internal Medicine,* 135**,** 221-227.

COX, E. D., SMITH, M. A., BROWN, R. L. & FITZPATRICK, M. A. 2008. Assessment of the physician–caregiver relationship scales (PCRS). *Patient Education and Counseling,* 70**,** 69-78.

CRYSTAL, D. 2004. *Rediscover Grammar,* London, Pearson Education.

CUTCLIFFE, J. R. 2000. Methodological issues in grounded theory. *Journal of Advanced Nursing,* 31**,** 1476-1484.

DAVIS, C. M. 1990. What Is Empathy, and Can Empathy Be Taught? *Physical Therapy,* 70**,** 707-711.

DAVIS, M. 1980. A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology,* 10.

DAVIS, M. H. 1983. Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology,* 44**,** 113-126.

DAVIS, M. H. 1994. *Empathy: A social psychological approach,* Madison, WI, Brown and Benchmark.

DE WAAL, F. B. M. 2005. *The Evolution of Empathy* [Online]. Available: http://www.hum.utah.edu/~bbenham/Minds%20and%20Morals/Evolution%20of%20empathy_deWaal.pdf [Accessed 08/06 2010].

DECETY, J. & ICKES, W. (eds.) 2009. *The Social Neuroscience of Empathy,* Massachusetts: MIT.

DENSCOMBE, M. 2003. *The Good Research Guide for Small-scale Social Research Projects,* Maidenhead, Open University Press.

DIMATTEO, M. R. 1994. Enhancing patient adherence to medical recommendations. *JAMA,* 271**,** 79-83.

DISEKER, R. A. & MICHIELUTTE, R. 1981. An analysis of empathy in medical students before and following clinical experience. *Journal of Medical Education,* 56**,** 1004-10.

DONOVAN, J. L. 1995. Patient Decision Making: The Missing Ingredient in Compliance Research. *International Journal of Technology Assessment in Health Care,* 11**,** 443-455.

DOW, A., LEONG, D., ANDERSON, A., WENZEL, R. & TEAM, V. C. U. T.-M. 2007. Using Theater to Teach Clinical Empathy: A Pilot Study. *Journal of General Internal Medicine,* 22**,** 1114-1118.

DREW, P., CHATWIN, J. & COLLINS, S. 2001. Conversation analysis: a method for research into interactions between patients and health-care professionals. *Health Expectations,* 4**,** 58-70.

DREW, P. & HERITAGE, J. 1992. *Talk at Work,* Cambridge, Cambridge University Press.

DUAN, C. & HILL, C. E. 1996. The Current State of Empathy Research. *Journal of Counseling Psychology,* 43**,** 261-274.

EIDE, H., FRANKEL, R., HAAVERSEN, A. C. B., VAUPEL, K. A., GRAUGAARD, P. K. & FINSET, A. 2004. Listening for feelings: identifying and coding empathic and potential empathic opportunities in medical dialogues. *Patient Education and Counseling,* 54**,** 291-297.

EISENBERG, N. & EGGUM, N. 2009. *The Social Neuroscience of Empathy,* Massachusetts, MIT Press.

ELIZUR, A. & ROSENHEIM, E. 1982. Empathy and attitudes among medical students: the effects of group experience. *Academic Medicine,* 57**,** 675-83.

EVANS, B. J., STANLEY, R. O., BURROWS, G. D. & SWEET, B. 1987. Comparison of skills related to effectiveness of consultations: An Australian sample of medical students. *Psychological Reports,* 61**,** 419-422.

FADLON, J., PESSACH, I. & TOKER, A. 2004. Teaching Medical Students What They Think They Already Know. *Education for Health: change in Learning and Practice,* 17**,** 35 - 41.

FERNÁNDEZ-OLANO, J, M.-F. & S, S.-S. A. 2008. Impact of clinical interview training on the empathy level of medical students and medical residents. *Medical Teacher,* 30**,** 322-324.

FIELDS, S. K., HOJAT, M., GONNELLA, J. S., MANGIONE, S., KANE, G. & MAGEE, M. 2004. Comparisons of Nurses and Physicians on an Operational Measure of Empathy. *Evaluation & the Health Professions,* 27**,** 80-94.

FINE, V. K. & THERRIEN, M. E. 1977. Empathy in the doctor-patient relationship: Skill training for medical students. *Journal of Medical Education,* 52**,** 752-757.

FOX, F. E., RODHAM, K. J., HARRIS, M. F., TAYLOR, G. J., SUTTON, J., SCOTT, J. & ROBINSON, B. 2009. Experiencing "The Other Side": A Study of Empathy and Empowerment in General Practitioners Who Have Been Patients. *Qual Health Res,* 19**,** 1580-1588.

FRANKEL, R. M. 2009. Empathy research: A complex challenge. *Patient Education and Counseling,* 75**,** 1-2.

FREE, N., GREEN, B., GRACE, M., CHERNUS, L. & WHITMAN, R. 1985. Empathy and outcome in brief focal dynamic therapy. *Am J Psychiatry,* 142**,** 917-921.

GILES, H. & COUPLAND, N. 1991. *Language: Contexts and Consequences (Mapping Social Psychology),* Milton Keynes, Open University Press.

GLASER, K. M., MARKHAM, F. W., ADLER, H. M., MCMANUS, P. R. & HOJAT, M. 2007. Relationships between scores on the Jefferson Scale of physician empathy, patient perceptions of physician empathy, and humanistic approaches to patient care: a validity study. *Medical Science Monitor,* 13**,** CR291-4.

GLAZER, B. & STRAUSS, A. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Chicago, Adline Publishing.

GMC. 1993. Tomorrow's Doctors: Recommendations on Undergraduate Medical Education. *GMC* [Online].

GMC. 2006. Good Medical Practice. *GMC* [Online]. Available: http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf.

GMC. 2009. Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education.

GOFFMAN, E. 1967. *Interaction Ritual: Essays on Face-to-Face Behaviour* New York, Doubleday Anchor.

GOLEMAN, D. 1996. *Emotional Intelligence: Why It Can Matter More than IQ,* London, Bloomsbury Publishing.

GOLEMAN, D. 2007. Social Intelligence: The New Science of Human Relationships [Conference Presentation]. *Authors@google.* California: Google.

GOLEMAN, D. 2009. *'empathy' - who's got it, who does not* [Online]. Available: http://danielgoleman.info/2009/empathy-whos-got-it-who-does-not/ [Accessed 16/11 2011].

GOMM, R. 2009. *Key Concepts in Social Research Methods,* Basingstoke, Palgrave Macmillan.

GRAUGAARD, P., HOLGERSEN, K. & FINSET, A. 2004. Communicating with Alexithymic and Non-Alexithymic Patients: An Experimental Study of the Effect of Psychosocial Communication and Empathy on Patient Satisfaction. *Psychother Psychosom,* 73**,** 92-100.

GREIF, E. B. & HOGAN, R. 1973. The theory and measurement of empathy. *Journal of Counseling Psychology,* 20**,** 280-284.

GRICE, H. P. 1975. Logic and Conversation. *In:* JAWORSKI, A. & COUPLAND, N. (eds.) *The Discourse Reader.* Abingdon: Routledge.

GRUNDY, P. 2008. *Doing Pragmatics,* London, Hodder Education.

GUBA, E. & LINCOLN, Y. 1994. Competing Paradigms in Qualitative Research. *In:* DENZIN, N. & LINCOLN, Y. (eds.) *Handbook of Qualtiative Research.* 1st ed. California: Sage.

HALPERN, J. 2001. *From Detached Concern to Emapthy: Humanizing Medical Practice,* USA, Oxford University Press.

HALPERN, J. 2003. What is Clinical Empathy? *Journal of General Internal Medicine,* 18**,** 670-674.

HALPERN, J. 2007. Empathy and Patient–Physician Conflicts. *Journal of General Internal Medicine,* 22**,** 696-700.

HARRES, A. 1998. 'But You're Basically Feeling Well, Are You?': Tag Questions in Medical Consultations. *Health Communication,* 10**,** 111-123.

HART, C. N., DROTAR, D., GORI, A. & LEWIN, L. 2006. Enhancing parent–provider communication in ambulatory pediatric practice. *Patient Education and Counseling,* 63**,** 38-46.

HEMMERDINGER, J., STODDART, S. & LILFORD, R. 2007. A systematic review of tests of empathy in medicine. *BMC Medical Education,* 7**,** 24.

HERITAGE, J. & LINDSTRÖM, A. frth. Knowledge, Empathy and Emotion in a Medical Encounter. *In:* PERÄKYLÄ, A. & SORJONEN, M. (eds.) *Emotion and Affect in Interaction.* Oxford: Oxford University Press.

HERITAGE, J. & MAYNARD, D. 2006. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients,* New York, Cambridge University Press.

HICKEY, G. 1997. The use of literature in grounded theory. *Nursing Times Research,* 2**,** 371-378.

HICKMAN, G. B., CLAYTON, E. W., ENTMAN, S. S., MILLER, C. S., GITHENS, P. B., WHETTEN-GOLDSTEIN, K. & SLOAN, F. A. 1994. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA,* 272**,** 1583-1587.

HIPPOCRATES. 460-400 B.C. *Medical Quotations* [Online]. Available: http://www.doctorspage.net/quotes.asp [Accessed 14/05 2012].

HOGAN, R. 1969. Development of an empathy scale. *Journal of Consulting and Clinical Psychology,* 33**,** 307-316.

HOIJER, H. 1994. The Sapir-Whorf hypothesis. *In:* SAMOVAR, L. & PORTER, R. (eds.) *Intercultural communication: A reader.* 7th ed. California: Wadsworth.

HOJAT, M., GONNELLA, J. S., MANGIONE, S., NASCA, T. J., VELOSKI, J. J., ERDMANN, J. B., CALLAHAN, C. A. & MAGEE, M. 2002a. Empathy in medical students as related to academic performance, clinical competence and gender. *Medical Education,* 36**,** 522-527.

HOJAT, M., GONNELLA, J. S., NASCA, T. J., MANGIONE, S., VERGARE, M. & MAGEE, M. 2002b. Physician Empathy: Definition, Components,

Measurement, and Relationship to Gender and Specialty. *Am J Psychiatry,* 159**,** 1563-1569.

HOJAT, M., MANGIONE, S., KANE, G. C. & GONNELLA, J. S. 2005. Relationships between scores of the Jefferson Scale of Physician Empathy (JSPE) and the Interpersonal Reactivity Index (IRI). *Medical Teacher,* 27**,** 625-628.

HOJAT, M., MANGIONE, S., NASCA, T., COHEN, M. J. M., GONNELLA, J., ERDMANN, J. B., VELOSKI, J. & MAGEE, M. 2001. The Jefferson Scale of Physician Empathy: Development and Preliminary Psychometric Data. *Educational and Psychological Measurement,* 61**,** 349-365.

HOJAT, M., MANGIONE, S., NASCA, T. J., RATTNER, S., ERDMANN, J. B., GONNELLA, J. S. & MAGEE, M. 2004. An empirical study of decline in empathy in medical school. *Medical Education,* 38**,** 934-941.

HOJAT, M., VERGARE, M. J., MAXWELL, K., BRAINARD, G., HERRINE, S. K., ISENBERG, G. A., VELOSKI, J. & GONNELLA, J. S. 2009. The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. *Academic Medicine,* 84**,** 1182-1191 10.1097/ACM.0b013e3181b17e55.

HOLM & ASPEGREN 1999. Pedagogical methods and affect tolerance in medical students. *Medical Education,* 33**,** 14-18.

HOLTON, J. 2007. The Coding Process and Its Challenges. *In:* BRYANT, A. & CHARMAZ, K. (eds.) *The Sage Handbook of Grounded Theory.* London: Sage.

HORNBLOW, A. R., KIDSON, M. A. & JONES, K. V. 1977. Measuring medical students' empathy: a validation study. *Medical Education,* 11**,** 7-12.

HUTCHBY, I. & WOOFITT, R. 2008. *Conversation Analysis,* Cambridge, Polity Press.

HUTCHINSON, S. A. & WILSON, H. 1993. Grounded theory: the method. *In:* MUNHALL, P. & BOYD, C. (eds.) *Nursing Research: A Qualitative Perspective.* New York: National League for Nursing Press.

JARSKI, R. W. & ET AL. 1985. A comparison of four empathy instruments in simulated patient–medical student interactions. *Journal of Medical Education,* 60**,** 545-551.

JEFFERSON, G. 2004. Glossary of Transcript Symbols with an Introduction. *In:* LERNER, G. (ed.) *Conversation Analysis: Studies from a First Generation.* Amsterdam/Philadelphia: John Benjamins.

JENA, A. B., SEABURY, S., LAKDAWALLA, D. & CHANDRA, A. 2011. Malpractice Risk According to Physician Specialty. *New England Journal of Medicine,* 365**,** 629-636.

KARSTEN, S. 2013. *'Empathy', The Standford Encyclopedia of Philosophy (Spring 2013 Edition)* [Online]. Available: http://plato.stanford.edu/archives/spr2013/entries/empathy/ [Accessed].

KAUSS, D. R., ROBBINS, A. S., ABRASS, I., BAKAITIS, R. F. & ANDERSON, L. A. 1980. The long-term effectiveness of interpersonal skills training in medical schools. *Academic Medicine,* 55**,** 595-601.

KEYSERS, C., WICKER, B., GAZZOLA, V., ANTON, J.-L., FOGASSI, L. & GALLESE, V. 2004. A Touching Sight: SII/PV Activation during the Observation and Experience of Touch. *Neuron,* 42**,** 335-346.

KIM, S. S., KAPLOWITZ, S. & JOHNSTON, M. V. 2004. The Effects of Physician Empathy on Patient Satisfaction and Compliance. *Evaluation & the Health Professions,* 27**,** 237-251.

KLISZCZ, J., HEBANOWSKI, M. & REMBOWSKI, J. 1998. Emotional and cognitive empathy in medical schools. *Academic Medicine,* 73**,** 541.

KLISZCZ, J., NOWICKA-SAUER, K., TRZECIAK, B., NOWAK, P. & SADOWSKA, A. 2006. Empathy in health care providers--validation study of the Polish version of the Jefferson Scale of Empathy. *Advances in Medical Sciences,* 51**,** 219-25.

KUPFER, D. J., DREW, F. L., CURTIS, E. K. & RUBINSTEIN, D. N. 1978. Personality style and empathy in medical students. *Journal of Medical Education,* 53**,** 507-509.

KURTZ, S., SILVERMAN, J. & DRAPER, J. 2005. *Teaching and Learning Communication Skills in Medicine,* Abingdon, Radcliffe Publishing.

LABOV, W. 1966. *The Social Stratification of English in New York City,* Washington, D.C., Center for Applied Linguistics.

LARSON, E. B. & YAO, X. 2005. Clinical Empathy as Emotional Labor in the Patient-Physician Relationship. *JAMA: The Journal of the American Medical Association,* 293**,** 1100-1106.

LASAGNA, L. 1964. *Hippocratic Oath: Modern Version* [Online]. Available: http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html [Accessed].

LATVALA, E., VUOKILA-OIKKONEN, P. & JANHONEN, S. 2000. Videotaped recording as a method of participant observation in psychiatric nursing research. *Journal of Advanced Nursing,* 31**,** 1252-1257.

LEVINSON, S. 1987. *Pragmatics,* Cambridge, Cambridge University Press.

LEVINSON, W., GORAWARA-BHAT, R. & LAMB, J. 2000. A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings. *JAMA: The Journal of the American Medical Association,* 284**,** 1021-1027.

LEWIS, T. 2007. The Neuroscience of Empathy [Conference Presentation]. *Authors@google.* California: Google.

LICHTON, A. 1995. The effects of audio and videotaping on selected Rorschah variables. *Dissertation Abstracts International: ProQuest Information and Learning,* 56**,** 2378.

LIEF, H. 1963. *The psychological basis of medical practice,* New York, Harper and Row.

LIM, B. T., MORIARTY, H. & HUTHWAITE, M. 2011. "Being-in-role": A teaching innovation to enhance empathic communication skills in medical students. *Medical Teacher,* 33**,** e663-e669.

LINCOLN, Y. & GUBA, E. 1985. *Naturalistic Enquiry,* Newbury Park, California, Sage Publications.

MANGIONE, S., KANE, G. C., CARUSO, J. W., GONNELLA, J. S., NASCA, T. J. & HOJAT, M. 2002. Assessment of empathy in different years of internal medicine training. *Medical Teacher,* 24**,** 370-373.

MARCI, C. & ORR, S. 2006. The Effect of Emotional Distance on Psychophysiologic Concordance and Perceived Empathy Between Patient and Interviewer. *Applied Psychophysiology and Biofeedback,* 31**,** 115-128.

MARTINOVSKI, B., TRAUM, D. & MARSELLA, S. 2007. Rejection of Empathy in Negotiation. *Group Decision and Negotiation,* 16**,** 61-76.

MAYNARD, D. W. 2006. “Does it mean I’m gonna die?”: On meaning assessment in the delivery of diagnostic news. *Social Science & Medicine,* 62**,** 1902-1916.

MCGHEE, G., MARLAND, G. R. & ATKINSON, J. M. 2007. Grounded theory research: literature reviewing and reflexivity. *Journal of Advanced Nursing,* 60**,** 334-342.

MEHRABIAN, A. 2010. The Balanced Emotional Empathy Test (BEES) and Optional Software. *http://www.kaaj.com/psych/scales/emp.html*.

MERCER, S. W. & HOWIE, J. G. R. 2006. CQI-2 — a new measure of holistic interpersonal care in primary care consultations. *British Journal of General Practice,* 56**,** 262-268.

MERCER, S. W., JANI, B. D., MAXWELL, M., WONG, S. Y. S. & WATT, G. C. M. 2012. Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socioeconomic deprivation in Scotland. *BMC Family Practice,* 13.

MERCER, S. W., MAXWELL, M., HEANEY, D. & WATT, G. C. 2004. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Family Practice,* 21**,** 699-705.

MOORE, P. J., ALDER, N. E. & ROBERTSON, P. A. 2000. Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions. *Western Medical Journal,* 173**,** 244-250.

MOORHEAD, R. & WINEFIELD, H. 1991. Teaching Counselling Skills to Fourth-year Medical Students: A Dilemma Concerning Goals. *Family Practice,* 8**,** 343-346.

MORSE, D. S., EDWARDSEN, E. A. & GORDON, H. S. 2008. Missed Opportunities for Interval Empathy in Lung Cancer Communication. *Arch Intern Med,* 168**,** 1853-1858.

MORSE, J. (ed.) 1994. *Emerging from the Data: Cognitive Processes of Analysis in Qualitative Research,* California: Sage.

NEUMANN, M., EDELHÄUSER, F., TAUSCHEL, D., FISCHER, M. R., WIRTZ, M., WOOPEN, C., HARAMATI, A. & SCHEFFER, C. 2011. Empathy

decline and its reasons: a systematic review of studies with medical students and residents. *Academic Medicine,* 86**,** 996-1009.

NEUMANN, M., WIRTZ, M., BOLLSCHWEILER, E., MERCER, S. W., WARM, M., WOLF, J. & PFAFF, H. 2007. Determinants and patient-reported long-term outcomes of physician empathy in oncology: A structural equation modelling approach. *Patient Education and Counseling,* 69**,** 63-75.

NEWTON, B. W., BARBER, L., CLARDY, J., CLEVELAND, E. & O'SULLIVAN, P. 2008. Is There Hardening of the Heart During Medical School? *Academic Medicine,* 83**,** 244-249 10.1097/ACM.0b013e3181637837.

NEWTON, B. W., SAVIDGE, M. A., BARBER, L., CLEVELAND, E., CLARDY, J., BEEMAN, G. & HART, T. 2000. Differences in medical students' empathy. *Academic Medicine,* 75**,** 1215.

NEZLEK, J. 2002. Day-to-Day Relationships Between Self-Awareness, Daily Events, and Anxiety. *Journal of Personality,* 70**,** 249-275.

NICOLAI, J., DEMMEL, R. & HAGEN, J. 2007. Rating Scales for the Assessment of Empathic Communication in Medical Interviews (REM): Scale Development, Reliability, and Validity. *Journal of Clinical Psychology in Medical Settings,* 14**,** 367-375.

NORFOLK, T., BIRDI, K. & WALSH, D. 2007. The role of empathy in establishing rapport in the consultation: a new model. *Medical Education,* 41**,** 690-697.

OED 2009. *Oxford English Dictionary Online.* Oxford: Oxford University Press.

OGDEN, J., BAVALIA, K., BULL, M., FRANKUM, S., GOLDIE, C., GOSSLAU, M., JONES, A., KUMAR, S. & VASANT, K. 2004. "I want more time with my doctor": a quantitative study of time and the consultation. *Family Practice,* 21**,** 479-483.

ONG, L. M. L., DE HAES, J. C. J. M., HOOS, A. M. & LAMMES, F. B. 1995. Doctor-patient communication: A review of the literature. *Social Science & Medicine,* 40**,** 903-918.

OSLER, W. 1932. *Aequanimitas: with other addresses to medical students, nurses, and practitioners of medicine,* New York, McGraw-Hill.

PAASCHE-ORLOW, M. & ROTER, D. 2003. The Communication Patterns of Internal Medicine and Family Practice Physicians. *J Am Board Fam Pract,* 16**,** 485-493.

PARSONS, T. 1951. Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry,* 21**,** 452-460.

PEABODY, F. W. 1927. The Care of the Patient. *Journal of the American Medical Association,* 88**,** 877-882.

PEDERSEN, R. 2009. Empirical research on empathy in medicine--A critical review. *Patient Education and Counseling,* 76**,** 307-322.

PELLEGRINO, G., FADIGA, L., FOGASSI, L., GALLESE, V. & RIZZOLATTI, G. 1992. Understanding motor events: a neurophysiological study. *Experimental Brain Research,* 91**,** 176-180.

PENNER, L., OROM, H., ALBRECHT, T., FRANKS, M., FOSTER, T. & RUCKDESCHEL, J. 2007. Camera-related behaviours during video recorded medical interactions. *Journal of Nonverbal Behaviour,* 31**,** 99-117.

PILNICK, A. & DINGWALL, R. 2011. On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review. *Social Science and Medicine,* 72**,** 1374-1382.

PINKER, S. 2008. *The Stuff of Thought: Language as a Window into Human Nature,* London, Penguin Books.

PLATT, F. & KELLER, V. 1994. Empathic communication. *Journal of General Internal Medicine,* 9**,** 222-226.

PLATT, F. W. & MCMATH, J. C. 1979. Clinical Hypocompetence: The Interview. *Annals of Internal Medicine,* 91**,** 898-902.

POLLAK, K. I., ALEXANDER, S. C., TULSKY, J. A., LYNA, P., COFFMAN, C. J., DOLOR, R. J., GULBRANDSEN, P. & ØSTBYE, T. 2011. Physician Empathy and Listening: Associations with Patient Satisfaction and Autonomy. *The Journal of the American Board of Family Medicine,* 24**,** 665-672.

POLLAK, K. I., ARNOLD, R. M., JEFFREYS, A. S., ALEXANDER, S. C., OLSEN, M. K., ABERNETHY, A. P., SUGG SKINNER, C., RODRIGUEZ, K. L. & TULSKY, J. A. 2007. Oncologist Communication About Emotion During Visits With Patients With Advanced Cancer. *Journal of Clinical Oncology,* 25**,** 5748-5752.

POOLE, A. D. & SANSON-FISHER, R. W. 1979. Understanding the patient: A neglected aspect of medical education. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology,* 13**,** 37-43.

POOLE, A. D. & SANSON-FISHER, R. W. 1980. Long-term effects of empathy training on the interview skills of medical students. *Patient Counselling and Health Education,* 2**,** 125-127.

PRINGLE, M. & STEWART-EVANS, C. 1990. Does awareness of being video recorded affect doctors' consultation behaviour. *British Journal of General Practice,* 40**,** 455-458.

PUDLINSKI, C. 2005. Doing empathy and sympathy: caring responses to troubles tellings on a peer support line. *Discourse Studies,* 7**,** 267-288.

ROBERTS, C., WASS, V., JONES, R., SARANGI, S. & GILLETT, A. 2003. A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students. *Medical Education,* 37**,** 192-201.

ROGERS, C. 1959. A Theory of Therapy, Personality and Interpersonal Relationships. *In:* KOCK, S. (ed.) *Psychology: A Study of Science.* New York: Mc Graw Hill.

ROSEN, I. M., GIMOTTY, P. A., SHEA, J. A. & BELLINI, L. M. 2006. Evolution of Sleep Quantity, Sleep Deprivation, Mood Disturbances, Empathy, and Burnout among Interns. *Academic Medicine,* 81**,** 82-85.

ROSENTHAL, S., HOWARD, B., SCHLUSSEL, Y. R., HERRIGEL, D., SMOLARZ, B. G., GABLE, B., VASQUEZ, J., GRIGO, H. & KAUFMAN, M. 2011. Humanism at Heart: Preserving Empathy in Third-Year Medical Students. *Academic Medicine,* 86**,** 350-358 10.1097/ACM.0b013e318209897f.

ROTER, D. 1989. *The Roter Method of Interaction Process Analysis,* Baltimore, Johns Hopkins University.

ROTER, D. & LARSON, S. 2002. The Roter interaction analysis system (RIAS): utility and flexibility for analysis of medical interactions. *Patient Education and Counseling,* 46**,** 243-251.

ROTER, D. L., LARSON, S., SHINITZKY, H., CHERNOFF, R., SERWINT, J. R., ADAMO, G. & WISSOW, L. 2004. Use of an innovative video feedback

technique to enhance communication skills training. *Medical Education,* 38**,** 145-157.

RUUSUVUORI, J. 2005. "Empathy" and "Sympathy" in Action: Attending to Patients' Troubles in Finnish Homeopathic and General Practice Consultations. *Social Psychology Quarterly,* 68**,** 204-222.

RUUSUVUORI, J. 2007. Managing affect: integration of empathy and problem-solving in health care encounters. *Discourse Studies,* 9**,** 597-622.

SACKS, H., SCHEGLOFF, E. A. & JEFFERSON, G. 1974. A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language,* 50**,** 696-735.

SATTERFIELD, J. M. & ELLEN, H. 2007. Emotion skills training for medical students: a systematic review. *Medical Education,* 41**,** 935-941.

SCHATZMAN, L. 1991. Dimensional analysis: notes on an alternative approach to the grounding of theory in qualitative research. *In:* MAINES, D. (ed.) *Social Organisation and Social Process: Essays in Honor of Anselm Strauss.* New York: Aldine de Gruyter.

SCHEGLOFF, E. A., JEFFERSON, G. & SACKS, H. 1977. The preference for self-correction in the organisation of repair in conversation. *Language,* 53**,** 361-382.

SCHULMAN-GREEN, D. 2003. Coping mechanisms of physicians who routinely work with dying patients. *Omega: Journal of Death and Dying,* 47**,** 253-264.

SCHÜRMANN, M., HESSE, M. D., STEPHAN, K. E., SAARELA, M., ZILLES, K., HARI, R. & FINK, G. R. 2005. Yearning to yawn: the neural basis of contagious yawning. *NeuroImage,* 24**,** 1260-1264.

SCHWANDT, T. 1994. Constructivist, Interpretivist Approaches to Human Inquiry. *In:* DENZIN, N. & LINCOLN, Y. (eds.) *Handbook of Qualtiative Research.* California: Sage.

SHANAFELT, T. D., WEST, C., ZHAO, X., NOVOTNY, P., KOLARS, J., HABERMANN, T. & SLOAN, J. 2005. Relationship Between Increased Personal Well-Being and Enhanced Empathy Among Internal Medicine Residents. *Journal of General Internal Medicine,* 20**,** 559-564.

SHAPIRO, J., MORRISON, E. H. & BOKER, J. R. 2004. Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and

Medicine Course. *Education for Health: Change in Learning & Practice (Taylor & Francis Ltd),* 17**,** 73-84.

SHAW, S. L. 2005. Grandparent Involvement in the Communication Development of Children Who Are Deafblind. [References]. *Educational Gerontology,* 31**,** 51-71.

SILVERMAN, D. 2010. *Doing Qualitative Research,* London, Sage Publications.

SILVERMAN, J. 2007. The Calgary-Cambridge guides: the 'teenage years'. *The Clinical Teacher,* 4**,** 87-93.

SILVERMAN, J. 2009. Teaching clinical communication: A mainstream activity or just a minority sport? *Patient Education and Counseling,* 76**,** 361-367.

SILVERMAN, J., KURTZ, S. & DRAPER, J. 2004. *Skills for Communicating with Patients,* Oxford, Radcliffe.

SKELTON, J. R., MACLEOD, J. A. A. & THOMAS, C. P. 2000. Teaching literature and medicine to medical students, part II: why literature and medicine? *The Lancet,* 356**,** 2001-2003.

SONNEX, C. 2008. Empathy: improving the quality of the genitourinary medicine consultation. *International Journal of STD and AIDs,* 19**,** 73-76.

SPIRO, H. 1992. What Is Empathy and Can It Be Taught? *Annals of Internal Medicine,* 116**,** 843-846.

SPIRO, H., PESCHEL, E., MCCREA CURNEN, M. G. & JAMES, D. S. 1996. *Empathy and the Practice of Medicine,* London, Yale University Press.

SQUIER, R. W. 1990. A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. *Social Science & Medicine,* 30**,** 325-339.

SRITHARAN, K., RUSSELL, G., FRITZ, Z., WONG, D., ROLLIN, M., DUNNING, J., MORGAN, P. & SHEEHAN, C. 2001. Medical oaths and declarations. *BMJ (Clinical research ed.),* 323**,** 1440-1441.

STEENSIG, J. & DREW, P. 2008. Introduction: questioning and affiliation/disaffiliation in interaction. *Discourse Studies,* 10**,** 5-15.

STEPHAN, W. G. & FINLAY, K. 1999. The Role of Empathy in Improving Intergroup Relations. *Journal of Social Issues,* 55**,** 729-743.

STERN, P. 1980. Grounded theory methodology its uses and applications. *Image,* 12**,** 20-23.

STRATTON, T. D., ELAM, C. L., MURPHY-SPENCER, A. E. & QUINLIVAN, S. L. 2005. Emotional Intelligence and Clinical Skills: Preliminary Results from a Comprehensive Clinical Performance Examination. *Academic Medicine,* 80**,** S34-S37.

STRAUSS, A. & CORBIN, J. 1994. Grounded theory methodology: an overview. *In:* DENZIN, N. & LINCOLN, Y. (eds.) *Handbook of Qualitative Research.* London: Sage.

SUCHMAN, A. L., MARKAKIS, K., BECKMAN, H. B. & FRANKEL, R. 1997. A Model of Empathic Communication in the Medical Interview. *JAMA,* 277**,** 678-682.

SUCHMAN, A. L., ROTER, D., GREEN, M. & LIPKIN, M. J. 1993. Physician Satisfaction With Primary Care Office Visits. *Medical Care,* 31**,** 1083-1092.

TANNEN, D. 1989. *Talking Voices: Repetition, Dialogue and Imagery in Conversational Discourse,* Cambridge, Cambridge University Press.

TAVAKOL, S., DENNICK, R. & TAVAKOL, M. 2012. Medical Students' Understanding of Empathy. *Medical Education,* 46**,** 723.

TAYLOR, M. B. 1997. Compassion: Its Neglect and Importance. *British Journal of General Practice,* 47**,** 521-523.

TEN HAVE, P. 2011. *Doing Conversation Analysis: A Practical Guide,* London, Sage.

THOMAS, M., DYRBYE, L., HUNTINGTON, J., LAWSON, K., NOVOTNY, P., SLOAN, J. & SHANAFELT, T. 2007. How Do Distress and Well-being Relate to Medical Student Empathy? A Multicenter Study. *Journal of General Internal Medicine,* 22**,** 177-183.

TOGNINI-BONELLI, E. 2001. *Corpus Linguistics at Work,* Amsterdam, John Benjamins.

VAN DEN BRINK-MUINEN, A. & CARIS-VERHALLEN, W. 2003. Doctors' responses to patients' concerns: Testing the use of sequential analysis. *Epidemiologia e Psichiatria Sociale,* 12**,** 92-97.

VAN DULMEN, A. M. 2002. Different perspectives of doctor and patient in communication. *International Congress Series,* 1241**,** 243-248.

VAN DULMEN, S. & VAN DEN BRINK-MUINEN, A. 2004. Patients 'preferences and experiences in handling emotions: a study on communication sequences

in primary care medical visits. *Patient Education and Counceling,* 55**,** 149-152.

VERMEIRE, E., HEARNSHAW, H., VAN ROYEN, P. & DENEKENS, J. 2001. Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics,* 26**,** 331-342.

WALTERS, P., TYLEE, A., FISHER, J. & GOLDBERG, D. 2007. Teaching junior doctors to manage patients who somatise: is it possible in an afternoon? *Medical Education,* 41**,** 995-1001.

WATSON, J. C. & GREENBERG, L. S. 2009. *The Social Neuroscience of Empathy,* Massachusetts, MIT Press.

WEBER, M. 1947. *The Theory of Social and Economic Organization* New York, Free Press.

WENG, H.-C., STEED, J., YU, S.-W., LIU, Y.-T., HSU, C.-C., YU, T.-J. & CHEN, W. 2011. The effect of surgeon empathy and emotional intelligence on patient satisfaction. *Advances in Health Sciences Education,* 16**,** 591-600.

WEST, C. P., HUNTINGTON, J. L., HUSCHKA, M. M., NOVOTNY, P. J., SLOAN, J. A., KOLARS, J. C., HABERMANN, T. M. & SHANAFELT, T. D. 2007. A Prospective Study of the Relationship between Medical Knowledge and Professionalism among Internal Medicine Residents. *Academic Medicine,* 82**,** 587-592 10.1097/ACM.0b013e3180555fc5.

WEST, C. P., HUSCHKA, M. M., NOVOTNY, P. J., SLOAN, J. A., KOLARS, J. C., HABERMANN, T. M. & SHANAFELT, T. D. 2006. Association of Perceived Medical Errors With Resident Distress and Empathy. *JAMA: The Journal of the American Medical Association,* 296**,** 1071-1078.

WILSON, H. & HUTCHINSON, S. 1991. Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research,* 1**,** 263-276.

WINEFIELD, H. R. & CHUR-HANSEN, A. 2000. Evaluating the outcome of communication skill teaching for entry-level medical students: does knowledge of empathy increase? *Medical Education,* 34**,** 90-94.

WOLOSCHUK, W., HARASYM, P. H. & TEMPLE, W. 2004. Attitude change during medical school: a cohort study. *Medical Education,* 38**,** 522-534.

WOOFITT, R. 2005. *Convesation Analysis and Discourse Analysis,* London, Sage.

WYNN, R. 2005. Empathy in general practice consultations: a qualitative analysis. *Epidemiologia e Psichiatria Sociale,* 14**,** 163-9.

WYNN, R. & WYNN, M. 2006. Empathy as an interactionally achieved phenomenon in psychotherapy: Characteristics of some conversational resources. *Journal of Pragmatics,* 38**,** 1385-1397.

YULE, G. 2000. *Pragmatics,* Oxford, Oxford University Press.

ZAHN-WAXLER, C. & RADKE-YARROW, M. 1990. The origins of empathic concern. *Motivation and Emotion,* 14**,** 107-130.

ZINN, W. 1993. The Empathic Physician. *Arch Intern Med,* 153**,** 306-312.

PPIRes Focus Group Transcription

AM: So before we start, are there any comments or questions about the project?

P1: Often it's what is not said that is more to the point I find.

AM: Mhmm. So are you saying it's more to do with body language?

P1: Well it's body language and what is not said. You know um, I can give you an example. I had an emergency appointment at the hospital um and I went to go and I went in and the doctor didn't look at me. He just said 'name'. And it was not... you know if he'd said hello or I am. But I just feel myself withdrawing and I walked out. So it was what was not said then.

AM: That's a really good point in terms of what's not said and I think we'll be able to build on that today.

P2: It actually goes a bit further back than that because my wife has blood tests for regular bits and pieces in terms of the doctor's letter just said 'the doctor wants to see you' and we couldn't go for a week so you have a week thinking 'what is wrong'?

AM: Okay. So that's perhaps more on the administration side.

P2: Yes. But it's still linked in. Because you've got the tension before you get there.

AM: And would you say that that can affect the way you experience um or the rapport with the doctor to start off with.

P2: Yes because she was worried before she went in. And when she got in she was obviously terrified.

AM: Okay, any other questions or comments before we move on.

P3: I think for me it's that the doctor will listen. Um. I feel very comfortable when he says 'are there any questions'. But sometimes you don't know the question to ask, to get the answer you require. So I think, I like space to go back because then you can think about it and think oh why didn't I say that. But it's that space, yes.

AM: Okay so to start today, without talking to anyone else, can you just write down very briefly what you think empathy is.

panel members writing

AM: So do you want to read them out?

P2: Yeah to me it involves body language. The words used. Tone delivered in. Physical interaction from the doctor's face. Looking at the patient. Offering a chance for questions. Avoiding closed questioning or answering.

P1: Um. Mine was understanding patients and their feelings and having a connection.

P3: Ummm. An understanding of what is said and felt. Showing this understanding by words and gestures.

P4: Empathy is the feeling I've been understood; listened to, without judgment or without them being irritated by me. Which some doctors do you know?

AM: Okay so a couple of main things from that. Understanding was mentioned. What do you think that understanding relates to?

P2: I would say that if the doctor's actually read the patient's notes, he would have a little bit of understanding of how they were feeling. In-so-much as you know major events in their past. Then they might understand if they have anxiety or not.

AM: Mhmm, so you said felt there so would you say it's to do with emotions?

P2: Um. I just think that if they read the notes they would get a feeling for the patient. So it is emotions that make an understanding of the patient if they're very tense or etcetera etcetera.

P3: I think it is to do with emotions and I think that it is about being open and not having preconceived ideas.

P4: An example of that I was thinking of people who are very obese or have got a lump um I think that it would be quite easy for a doctor to be irritated by them but they really don't know what their life experiences or where they come from. And I think they've just got to be open and just sort of be a blank page for the patient to write on.

P1: He needs to appreciate he may well be dealing with this particular case five or six times a day. It's your first time. That's important.

AM: You also mentioned the words used.

P3: I often think there needs to be a clarification of words because if I say 'I'm angry, or anxious', or whatever the word you don't really *quite* understand. You understand it that angry might be terrible, but somehow in my book it means perhaps a bit irritated. So I think words can mislead sometimes.

P2: Not just the words but the tone the words are delivered in so they're not judgmental. Certainly shown with a smoker, who's got lung cancer. He can't say he's got lung cancer in a way that it's his fault.

AM: Okay, so that's more on the non-verbal. Did we also say body language?

P1: Yeah; eye contact is so important. I mean I know all this about health and hygiene, but you walk in and the doctor doesn't even look at you. I mean that's bad enough *and* shake your hand. So you know they can spray their hands afterwards if they want. But that's you know the initial meeting is so important because we make up our minds even though we don't know it but we make up our minds straight away.

AM: You mentioned the doctor not looking at you; what are your opinions on taking notes?

P1: You can take notes, but is there any reason why when I walk in you can't look at me and say 'hello, I'm doctor so-and-so', and then you can take notes. But it's the initial looking at you, and then you should then be able to read what's on my face, you know fear or whatever.

AM: And you said about shaking hands; would you always expect a handshake?

P1: Um, it's quite nice to have a handshake.

P2: I don't know if they need to take notes. I mean I go and visit my GP and he doesn't take notes when we're discussing the thing. He will talk about it and then he will take a few notes down. But he does look at you when he's talking to you.

P1: What about in a hospital; they don't take notes there.

P2: Yeah but you can be talking to the person and then you can state, 'I just need to write it down'. But when you're talking to them and when they're talking to you they should be looking up at you.

P1: But if you're going to say that it might break the flow of conversation.

P3: I think the introduction is more important for me than the handshake. I think to say, you know I'm doctor martin, I think particularly if you're going to examine me, I find that more important than shaking hands.

AM: Using the surname as well; is that important for you?

P3: Well because it's a more formal relationship isn't it?

P1: And sometimes you have other people in the room, and it's like 'who are you and why are you here'?

AM: Okay, and what would you (P4) say is the most important part?

P4: Well my own GP is absolutely smashing. When you go in he immediately excuses himself if he's kept you waiting, and then he turns around on his chair so you're facing him. And then he listens. And you come out of there, he may not have said anything at all to move the situation on, but you feel you've been heard. And that for me is important.

AM: When you say facing you, how is he sitting?

P4: *shows sitting at an angle, not directly facing* He will lighten things, you know, sometimes he'll say something that makes me laugh and you know that's really good because I feel relaxed. I don't feel worried when I go in to see him.

P2: At my practice, the doctor always comes to the door of the consulting room to meet every patient. It's not buzzers going. He comes to the doctor and calls you by name.

AM: So again that links to how the situation is set up, so would that fall into the empathetic side of things as well?

P2: I think it does because it sets the tone. He's trying to make you feel relaxed, comfortable, and encourage you to talk.

P3: In a hospital situation, if the doctor does show empathy, he gets more information from the patient. Whereas, if there's this barrier, I would go yes/no answers, and he was getting no information, and I just thought this is ridiculous. Whereas if he was nice, he could have got a lot of information in a short space of time.

AM: So I suppose that links with time as well.

P1: Yeah yeah, well we can give them little details that are so important. If you get a yes/no answer, you've got no information. I could mention something that was actually quite important inadvertently and they can pick up on that.

AM: *summarises discussion thus far* is there anything I've missed out or anything anyone would like to add?

P2: I think open questions, where's it's not just yes/no.

P3: And not coming from a preconceived idea, being more open to what might be communicated.

P1: But then you can ask questions and it can be a yes/no answer. Have you had this pain long? Yes. And I can leave it at that. Although I can say yes I've had it and it comes and goes. But then they'll say how long and I'll say three months. But then the real answer would be I've had it for a long time, but the last few months has been really bad.

AM: And what does P5 think?

P5: My description was 'being able to put yourself in the position of another person, being able to appreciate the feelings...

P1: But how can you appreciate the feelings.

P5: Without being...

P1: No.

P5: Condescending.

P1: Yeah, but you don't know how I'm feeling; you can't imagine how I'm feeling.

P3: I think you can try actually.

P2: Only if they'd read my notes and know my background.

P3: My perception was you've got to try to... otherwise you won't bother. I mean trying. You must be trying to know what the pain feels like for you.

P2: I think also every patient is different. I'm hot-headed and feisty. You know, and other people are calm and cool, so every patient's different. So when you say 'I understand how you feel', you can't.

P1: You can try to understand.

P2: But the doctor has to try to take on board every patient.

P4: I get the feeling now that years ago when I went the doctor was the professional, but now it's a partnership.

P2: It is important that the doctor acts professionally. If you're telling someone with cancer that they've got three months to live, it wouldn't help me if the doctor then burst into tears. They've got to somehow remain a little detached and professional, but still be sympathetic and empathetic.

panel is introduced to, and watch, clip 010

P2: Um. I didn't like her language. There were too many ums, yeahs, ahs.

P1: Yeah. Yeah.

P2: All the way through. She was... she said at a point she said thank you, which was good. When she was talking to him, she thanked him. Which I thought was good again with building rapport. The questions about haemorrhoids; did he understand or know anything about them, again is checking understanding. There was a good discussion about haemorrhoids. Um she gave him the patient time to ask questions. Gave him time to talk about the father. So that is a combination of checking understanding and rapport, it could come under either.

AM: Yeah.

P2: Because then yeah. Clear explanation of haemorrhoids so that was checking understanding. And again I got too many ums, yeahs. She listened to the patient about

the IBS. So that's checking understanding. Why not ask the medical history earlier, I wondered?

P3: I thought the IBS thing was a bit late. You know a bit fearful in the first stage and then she actually doesn't get to the IBS, when she's talking about the fibre, because he just throws it in, and I'd like to check what IBS was. You know, he might say he's got IBS, but...

P2: Well IBS is one of these wonderful things that covers all sorts of manifold sins. You can be going to the toilet all the time. You could be constipated all the time, and other problems. The thing that concerned me, she had quite a monotone.

P1: Every now and then she got bored. You could see she was bored. Her voice was *boring*. And that was annoying.

P2: So this thing about IBS is understanding. It's also rapport. Uhh, I don't know where you're going to put medical history should have come earlier. And rather monotone.

P1: And mumbling. She was mumbling.

P2: Yes. Yes she was.

AM: Okay. Thank you. P2?

P2: Um. Basiscally, um she was asking okay your age. I thought if she'd read his notes; that always annoys me. Okay I would say again blood vessels she was just boring me. It's boring boring. So she's really got to learn to keep her voice up to par.

AM: What about initially as well you said could I make her slow down.

P2: Yeah. Nu-nu-nu-nu. I didn't and a patient doesn't always hear. We pretend we do. But we don't hear. I know that sounds silly, but you can give us all the answers but it hasn't gone into our heads. Especially when it's a situation like that. Oh yeah and she was empathetic when it came to he was talking about worried about his father's cancer, and she said there are many other causes for bleeding. You know, she was good there.

AM: So what would that come under?

P1: Would it be rapport there? No that's not building a connection, is it?

P2: Reassurance. *long pause* Um. When we got to the bit when she was talking about I want to assure you that the problem is just treatable. Is she, she really getting very boring, and she didn't give him a chance to... I just felt like she should have been saying, you know if you are confirmed we can look further. She didn't give him... come on P1.

P1: Open ended questions. It was closed.

P2: It was closed.

P1: She was making statements. Yeah, that's what we're saying. Um. I don't think her reassurance was good, because I would have wanted to investigate further to really say no.

AM: mm

P1: It was all ums. The ums kept on coming in, and *well*. So she wasn't, that wasn't very good. Her voice towards the end was really you could hear it getting... so... boring.

AM: You keep saying her voice was boring. Does that relate to empathy in terms of...

P1: She wasn't in contact with the patient. It was like I'm just talking to the brick wall over there. You know and then when you're done you can have some treatment and then this happened, you know? Your voice can be your eyes as well as your ears.

P2: I mean I think there's a danger when some people speak, you switch off. I have a friend who's very turgid. Part way through whatever he says, my mind has switched off and I'm thinking about something else.

P1: I think she was losing the plot and she should have asked the patient a few more times, are you really happy with this, is there any... especially round the cancer area and his father because he was worried. Um. She didn't give enough reassurance. She didn't give enough information either. I don't think. Towards the end she was I understand you're worried etc etc. She was saying the right things, but again she was saying it, but she wasn't meaning it.

AM: So you didn't think that that was genuine.

P1: No I didn't. When she said don't worry, it'll be alright.

AM: Okay, is there anything else that you'd like to add?

P1: No, it's all here.

P3: Um. It says here checking that patient's comfort, and she sort of said that. But then umm, said yeah yeah. I mean I think she seemed to have asked most of the questions and some would lead on from there. They were the questions. Was she concerned about things, and was he concerned? Then, then it didn't go anywhere. I mean I thought her body language looked okay. It was difficult to see her whole body, but she was looking formal and she nodded. I don't think she smiled.

P1: She was near the end.

P3: I can't remember. But that looked okay. But it was almost as if she was very playing the doctor, rather than the human. As somehow there was lots of explanation; lots of options for treatments, but not that human contact I thought.

P2: Her hands together. Body language was a bit distant I would have thought. Yes, I think you're a bit distant to the person; you're not actually being open to them.

P3: Um. Yes, the bleeding that was the back passage I mean she gave her bit about the blood, I would sort of more reiterate what P2 has said. Because she did try to make it specific. I thought there were lots and lots of explanations. She seemed to explain a great deal I think, because at one point she says do you know much about haemorrhoids? Then he says it's something to do with the blood vessels and then she took over. So there wasn't a getting it from him. What he knew about haemorrhoids, apart from it was to do with blood vessels.

AM: Yeah, so it's one thing asking what the patient knows, but then if you're not going to let them tell you what they know

P3: YEAH. Yeah. And how can you possibly be empathic. It's like was it just on the loo paper the blood or was he, or were there pints and pints I mean. And so therefore she didn't really get to know it, and I think didn't allow herself the opportunity to be empathic. Because she was sort of there. But not quite.

P1: And I also think that with the treatments she wasn't helping him. She was asking, what do you want? So, you know... poor patient.

P3: I think at the end when she said not to worry.

laughter from group

P3: Don't *ever* say that. You say don't worry and my god you're going to worry aren't you.

P1: And relax.

P3: And when doctors say it will be uncomfortable, not painful. One of your things is affecting the day-to-day, and she sort of got there, in the partner was moaning, there was a teenage daughter, he was finding it uncomfortable at work, but I don't know that he knew she'd shown that she understood about that.

AM: How would you have said that she could have shown that she understood?

P3: By saying you know it sounds like it's really affecting your life.

P1: Yeah. And giving him some advice.

P3: She did tell him to have more fibre or that would discord the IBS.

P2: Pillow. One of the rings. Haha.

P3: So I think she could have said it sounds like you're really very frightened, and it's painful and it's affecting your life.

P4: I just wonder, if she's trying to extract a history from him isn't she? What has been happening to him. But as I say, she did most of the talking. And I would question if she was actually telling him too much in a way. I felt that she should have extracted the information, let him talk more, but then he's telling her all these things and really he should go back to his doctor, not – you should eat more fibre. I mean he'll go away and think oh well as long as I eat more fibre and do this and this. And then when she says about his teenage daughter, is she a teenager, but she's already told her she's 15, so you're wondering if she's hearing what he's saying.

AM: You said about treatments options.

P4: Yes, she said do any of them sounds appealing – well no none of them sounds appealing.

laughter from group

P1: So again, it seems as though she was reading off of a card. You can have this, this, this. Which one do you want? Special offer on such and such. So it was information and she tried to make it sounds empathetic but it just came across as 'I'm getting bored now'.

P4: I think she was anxious to do it properly, so she was giving him too much information. Whereas she should have let him talk more, and then from what he was saying I definitely think you should go back to see your doctor. It changes, when he said my dad had bleeding from his back passage, and turned out he had bowel cancer... there, I think she went into overdrive really about what you could do and what you couldn't do, and really at that point, and with all the things that he's saying is wrong with him, I don't think she would be stepping over her remit to say I think you should definitely go back to your doctor, and explain what's been happening

P3: But she isn't a doctor, she is a student and she's just trying to get a history from him.

P1: She should have asked, did you tell your doctor this?

P4: Yes, yeah.

P1: She should have asked that question, you know – did you talk to your doctor about this? Because that again could mean she doesn't pass the information on, he thinks that she has and it could be missed out, and that could be a very dangerous situation.

P4: As a patient you imagine that they're all communicating with each other, but having been around a hospital.

P1: Not necessarily, no.

P4: But nobody knows even where your notes are. So that was a very big thing for her to pick up on.

P3: Coming back to this point about missed opportunities, where he said what was the blood like? Wonderful, open question, tell me what it is like. And he says it's red. And then she takes over, it was red.

P1: I would have thought she'd like to know a bit more about that. Red. Red. Hmm.

P3: But again it's as though she's trying to give a diagnosis, which isn't what she's there for. She's just trying to get some information.

AM: Mmm

P3: Do they have pressures with time? Because I'm just thinking, one of the things with saying tell me more, is I've got to get this done in time you know. And I think that's quite hard. So it's a very delicate balance isn't it? Between being empathic, and getting the job done.

AM: Yeah.

P3: I'm just wondering if at any time that patient knew that somehow he'd been heard. To be able to say it seems to be affecting your life. I don't know that she did that.

AM: Did anyone notice that?

P3: Yes, she does say is there anything that concerns you about the cancer, but I don't think there were any other.

P1: So what sort of empathetic patient do we think she was?

P4: I think she's trying to be there.

P1: She got bored at the end.

P3: Who keeps the time.

AM: I do. Usually 10 minutes.

P2: But at the same time if somebody needs 11 or 12, they've got to give them it. And they must realise that.

P3: There is a fear that they'll go on and on and on and on.

P2: I think if they just rambled, they can gently tidy it up. But it may well be that at 10 minutes they haven't told them the final most important bit. I'm worried about my father having had cancer. So you've got to be aware of the time, but you've also got to be flexible and just allow people that minute of two if they need it. The whole way

through my surgery, there are notices *you have ten minutes time but if you need more, we'll give it to you.* To help patients understand.

P2: The other thing I felt was that, as she got more into the timing, she was adopting his manner of speech even more and more.

P1: Oh yes.

P2: Which as a patient, I might find slightly annoying.

AM: Oh really?

P3: Can you give an example P2?

P2: There'd be more um ahs yeahs.

P1: She must learn not to say 'yeah'.

P2: She is a professional. She speaks like a professional.

AM: So why would you say no to the yeah?

P1: It's just unprofessional. If she just said yeah to me I'd probably say yeah. You're the professional. I can say yeah at times, but you're the professional. Be the idol. The man. You know, all the time, I want to respect you, I need to respect you. Because you've got my life in your hands.

clip 003 viewed by panel

P4: His body position was good. He was leaning forward. He was listening, you got the feeling he was listening. He was listening to what she said to him.

AM: Was there anything in particular that made you think that he was listening?

P4: The way he had that sort of leaning, and he was closer, than with the other two. He was closer. And he kept checking with the patient – is this alright? And he also asked how did it affect your life. And the only thing was I wondered when he said more invasive, wonder if a lot of the public wouldn't know what invasive surgery meant. He might have lost them there. I know a lot a lot of people do understand what it means but it is a medical sort of word, rather than just an ordinary word. But I thought it was very good.

P3: I was very worried that he ignored that fact that she seemed to not be able to sit on the chair. And I think that was so obvious and he did say are you okay?

AM: Mhmm.

P3: And she was so obviously not okay I would have liked a comment about that she was obviously in a great deal of discomfort. I thought that he said you're in good company. Twice. Which was the bit about haemorrhoids being common. And then there was a sort of reassurance there and he seemed to agree with that, that there was a diagnosis. And he said sure sure you really want to get it. And another empathic response I thought was good, he did say it does sound terrible but it's not supposed to be painful. And the response was that she wanted them gone for good which I think he understood, that she needed to have them done and gone for good as it were. And I thought he warmed up; I thought he was quite hesitant in the beginning and I thought *please* say something about her being so uncomfortable, but he then sort of warmed up and I agree with P4: posture was much more accepting somehow.

AM: Thank you very much.

P1: Okay. I found in the beginning he had no connection with the patient. Um he introduced himself, but he didn't know her name. Which I thought was quite rude, again as I said, read notes etc. That was um bad. The beginning I thought he had no interest. Yes my niece is at medical school. Oh how nice you know what year is she or something.

AM: Mhmm.

P1: But he made no connection, no nothing. Um, further on he got really good, but the initial building of the confidence of the patient, doctor-patient let him down. Okay he seemed not interested in patient and yeah no connection with the patient further on. Um, good body language leaning towards, so in some ways his mouth wasn't saying what his body was saying. At one point, I didn't think he had much confidence, and I think that was the bit when it was the social chat. Once he got into the diagnosis and this is the treatments, he has confidence. But prior to that he didn't have confidence. He did explain the treatment, but I don't think he found out if she had any other worries I think. And again, some of his language 'sure sure', it's okay, but... And I think somewhere along the line he said have you got any but I think at the end he should have said is there anything else?

AM: Thank you very much.

P2: I think like most people he started off slowly. And he got better as he went along. I didn't like him interrupting the patient when she said about her niece being a medical student. Some doctors get very touchy when you use self-diagnosis. So not keen on that. Didn't like some of his language. Sure. Sure. He was going on about out-patients. The leaning forward I thought was good. And he was talking with his arms as well which I think is nice. He was also concerned about her comfort; he asked she was obviously sitting awkwardly – he was concerned about that. Was she okay. I wasn't actually convinced that he really knew what haemorrhoids are.

AM: Okay

P1: Yeah, there's a lining of the thing.

P2: Yes. It was somewhere in there, I wasn't sure. She self-diagnosed herself I felt, and he didn't then say have you discussed all this with the doctor? It's the IBS self-diagnosis. She said I've got IBS; he should have said have you discussed this with your doctor? I felt he was trying to be empathetic, explained technical terms but then he lost himself about the injections, he's got to explain that a little more clearly what the injections meant. He offers more information which was good. I immediately ran for the hills when he said we're running out of time.

P1: You don't tell a patient that.

P2: Don't say that to me. That really to me is a big NO.

AM: Right.

P2: I felt he appeared more interested and more positive as he went through. He seemed to get more comfortable with her. Or he likes the diagnosis, he likes talking about treatment, rather than the person.

AM: So as a group, which of the consultations we've seen today which would say is the more empathetic?

P4: Second one *echoed by group*

P1: Yeah maybe, but that start may have put me off, and I would have gone to my defensive mode.

P3: And did either say thank you very much at the end?

P2: She did.

AM: And would you say that's empathetic then?

P2: It's courteous, it's polite. It's mutual respect.

Participant 001

Student: good afternoon (.) my name’s khaled huss↑ain i’m a medical student (.) i understand th (.) that the doctor’s (.) let me let you know how sss uh °talk to you about why you’ve° come in today >is that okay<

Patient: yea that’s fine uh >my niece is a medical student< so

Student: is that ri↑ght

Patient: yeah so .hhh

Student: .hhh (.) well th↑ank you for letting me talk to you can i confirm (1.0) um your name please

Patient: um sss janice saunders

Student: okay and your age ple↑ase

Patient: fourty two

Student: fourty two (.) °okay° (.) can you let me know why you’ve come in today

Patient: um (.) well um i’ve i’ve come t-to see the GP today to talk about (.) um (1.0) er what we’re going to be doing next (.) hopefully treatment and that↑

Student: okay (.) in relation to °your haemorrhoids [that’s correct isn’t it°

Patient: [mm yeah

Student: okay (.) and >do you have any ideas about treatments<

Patient: not not really no

Student: mhmm

Patient: no i was hoping that he he would be able to go through that with me tod↑ay

Student: okay is there anything else you'd like to discuss or talk about

Patient: um (1.0) i was hoping really that we could talk about why (.) ya know maybe you think it's actually happened

Student: mhmm

Patient: um (0.5) and is there any chance ↑of (.) of them going away

Student: sure (.) okay (.) well they're reasonable questions to ask

Patient: mm

Student: you seem to be in a bit of discomfort now

Patient: yeah

Student: um (1.0) ha-has anyone talked to you about treatment options or anything

Patient: not treatment options (.) um (.) the um (.) the consultant i saw at at the hospi↓tal told me what he thought the problem was

Student: mmm

Patient: um (.) but he was a man of few words to be [.hhh to be to be honest

Student: [£oh i see£ okay

Patient: so um i was hoping that we could you know (.) cover that

Student: certainly (0.5) and what do you understand (.) what the options are at the mo↓ment °for you°

Patient: um (.) i don't i don't really know

Student: °don't know (.) okay°

Patient: um hmm i mean at the moment i would be (1.5) happy to consider anything really because it’s become (1.0) well they’ve become so so painful

Student: hmm

Patient: i really want to get them (0.5) sorted out (.) if i can

Student: °certainly (.) okay° so we’ll discuss the treatment options now um and if there’s anything else you want me to go through just stop me (.) if you don’t follow everything just stop me

Patient: okay

Student: i’ll go through it again (1.5) well um sss haemorrhoids can be staged from um (.) they’re they’re given stages >one two three and four<

Patient: yeah

Student: have you been explained stages

Patient: the um the doctor at the hospital said mine were a gr↑ade two

Student: gr↑ade two okay

Patient: mmm

Student: that’s (.) grade four’s most severe

Patient: huuu <u>rea</u>lly

Student: yes (.) and grade two (0.5) grade one being the (.) most LEAST severe

Patient: right

Student: and (.) two well you sort of sit in the middle

Patient: reall i can’t imagine it being (1.0) w<u>orse</u> than this actually

Student: i see (.) so you seem to be=

Patient: =it’s been excruciating the last six months

Student: the last six months

Patient: mmm

Student: okay (0.5) and um (0.5) how’s that affected your ˚life˚ >are you working at the moment<

Patient: well um i’m self employed

Student: mmm

Patient: my husband um well (0.5) we run um (0.5) a book bind↑ing and printing business together >just< at home

Student: mmm

Patient: um (.) but it has made (1.5) work really difficult cos it’s so sedentary re↑ally (.) and um (.) so what i have been doing the last (0.5) um (.) few months is ˚˚sitting on a (0.5) circular cushion˚˚

Student: i see

Patient: when i’m working cos sort of (.) that seems to help quite a lot

Student: yeah (.) sometimes bleeding is associated with haemorrhoids

Patient: definitely=

Student: =i understand you’ve had some

Patient: yeah

Student: um (.) i have a (.) prepared picture here describing haemorrhoids

Patient: [oh right

Student: [a un tha help describe (.) [the condition

Patient: [yeah

Student: and the different grades (.) um (.) grade one is shown here (0.5) are you

Patient: yeap go on

Student: grade one is just (.) shown here (.) it's um (.) higher up than the °anus° >this is the anus here<

Patient: yeah

Student: okay grade one's here <u>they're not visible</u> °they're not normally visible° (.) in examination

Patient: right

Student: and ↑grade <u>t</u>wo here (.) which um the doctor classified °you as° having grade two

Patient: mmm

Student: although they sometimes prolapse on ↓pressure

Patient: yeah

Student: okay they appear tts means they come out

Patient: that's happened before

Student: okay

Patient: yeah

Student: so you can possibly feel ↑them (.) °get pulled° (.) and then they (.) go back in for um um (1.0) for the completion of (.) evacuation of the stool er (.) that's grade two (.) and grade three is (.) erm (.) is a greater uu greater extent of prolapse (.) increased extent (.) and grade four is when they are really bad °n normally° outside the ↑anus

Patient: ↑really

Student: yes (1.0) so that that would be grade two (1.0) this one over there

Patient: i can’t i didn’t realise that it could get much worse to be honest >it looks< dreadful

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(ø) (2.5)

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Student: _____ mmk i (.) i will ss-certainly flag up your concerns with the doctor (.) and um (.) um i think i-it’s reasonable (.) to assume that you’d like this treated [as soon as possible

Patient: [yeah (.) yeah

Student: haemorrhoids are extremely common

Patient: mmm

Student: urm (.) up to half the population get haemorrhoids

Patient: really

Student: yes (0.5) i know you mentioned you asked why (1.0) it occurs

Patient: mm

Student: it can be related to several factors including diet

Patient: right

Student: and increased consti↑pa↓tion

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(ø) (2.5)

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Patient: _____ w-well um (.) i think (.) i'm pretty sure that i-i suffer with IBS um no one's ever told me that but i've had tummy trouble for (.) well over the last twenty ↑years really and um (2.0) and then i think it was in the news a ↓lot sort of seven or eight years ago n that's when i (1.0) i thought urr that's probably what (.) >what what< i get because it seems to come and go and then when i do have it i can either (1.0) be (0.5) constipated like you said or um (.) completely the opposite and i'm running backwards and forwards to the °toilet° and um (.) and that's when (.) they ↑seem worse

Student: i see

Patient: yeah

Student: has anyone actually discussed with you (0.5) er in regards your constipation or in terms of diet could be taken on board

Patient: um well uh i have mentioned it to the GP and he gave me some fibre gel (1.0) this is a few years ago now

Student: okay

Patient: and um (.) which uu i think i-it does help a bit but what i tend to do is just buy something similar over the co↑unter myself now

Student: mmm

Patient: when i need it (.) i-i don't take it all the ↓time

Student: oh right

Patient: i just use it when i need it

Student: and what's your (.) diet like

Patient: um i don’t eat meat (.) but i do eat fish and plenty of (0.5) plenty of fruit and vegetables actual↑ly

yea= (.) yea

Student: =that’s very good (.) and (.) your water intake is that good

Patient: um (.) i-i don’t think it’s too b↑ad aaih we sort of get (.) busy at work cos there’s just we have someone helping us >but but< most of the time there’s just the two of us n (1.0) and um (.) so <maybe i should be drinking more water now>

Student: that would help constipation (1.0) but it seems to me that you have a balanced diet

Patient: i think so yeah

Student: and how about exerc↑ise

Patient: um (.) n-not a huge amount to be honest

Student: okay (1.5) well these are preventative measures which would certainly help perhaps with the haemorrhoids because the reason why haemorrhoids partly occur is because of increased pressure

Patient: yeah

Student: and so (.) um (.) with the constipation str↑aining (1.0) that can obviously result in haemorrhoids happening

Patient: hmm

Student: um (.) do you find you actually strain on the to↓ilet

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(ø) (2.0)

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Patient: _____ um (.) i do i do when i go through that time (.) you know if i am a bit °°constipated°°

Student: well um p-p placing less strain at that point uh would be advisable because the again that would reduce the pressure↑↑ (.) and therefore um (.) with less pressure haemorrhoids would be unnatural with some luck

Patient: alright

Student: having said all that (0.5) um (.) haemorrhoids do occur n we don't really know what the real cause is but the risk factors in terms of pressure and constipation (.) they certainly do lead to haemorrhoids as well

Patient: right

Student: is that making sense

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(ø) (1.0)

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Patient: _____ yeah

Student: okay (.) so if tt i just want to make sure i've given the right message ↑to you (.) what do you understand as the main er what could what do you think you could do urm in terms of prevention

Patient: um (.) drink more water

Student: °↓m↑hmm°

Patient: i think urmm (2.0) try to [exercise a bit more

Student: [yeah

Patient: um (2.0) and i suppose when um if i do go to the loo and (1.0) and i am a bit constipated (1.0) not um (.) not to sort of

Student: mmm

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(ø) (2.0)

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Patient: _____ um strain too much

Student: okay (.) that's (.) i'm glad you've understood (.) you're obviously in pain >in terms of pain< are you taking any pain killers at the ↑mo↓ment

Patient: um well (.) not really no id d if if it gets too bad then i might just take like a neurofen or something but but but ↑really it's because it's almost constant now it used to sort of come and go it is almost constant

Student: well what i'd do is i'd um advise you to consult (.) the doctor in terms of pain killers (.) you could maybe even be prescribed something

Patient: mmm

Student: um maybe w-worth trying paracetamol capsules

Patient: right

Student: and in terms of actual um (0.5) treatment there are other treatments that i haven't (.) gone into in terms of surgical op↑tions

Patient: mmm

Student: but it may well be worth being referring to the hospital again to see the consultant

Patient: right

Student: um how does ↑that sound

Patient: um well well i’m happy if if he thinks that’s going to be worthwhile and it means i can sort of move for↓ward

Student: okay

Patient: i-i wouldn’t mind that at ↑all

Student: so i i’ll put those concerns to the doctor today

Patient: okay

Student: okay is there anything else you’d like to ask at the moment

Patient: just to make sure y’know jus to (1.0) sort of deal with the problem really↑

Student: okay (0.5) that’s very understandable (.) i’ll arrange another time to see the doctor at the hospital

Patient: okay (.) okay thank you

Student: thank you

Patient: thanks

Participant 002

Student: hello (.) good afternoon:n (.) is it mrs sau↑nders

Patient: yes

Student: um (.) my name is ↑siobhan ↓hallam (.) i'm a fourth year medical student (.) and um (.) i understand that the doctor's asked me (.) um asked you if it's alright to just have a quick discus↑sion with me um about the recent diagnosis you had

Patient: yeah

Student: and maybe some of the complications and treatment op↑tions [that are availa↑ble

Patient: [yes please (.) yeah

Student: is that still al↑right with you

Patient: that's f my niece is a medical student so (.) i understand it it's really important isn't it

Student: thank you very much

Patient: you're welcome

Student: just to let you know that anything we talk about is completely confidential

Patient: right thank you

Student: um are you sitting comfortably

Patient: ish

Student: okay well if you do want to stop at any time do just let me know okay=

Patient: =okay

Student: so um (0.5) just to begin um i understand that you've recently had some symptoms

that's you've had some investigations and a diagnosis

Patient: yeah

Student: would you mind just very briefly um picking out (.) the the key points (.) describing where we are at the moment

Patient: well i c↑ame to see the GP about six months ago cos things had got so bad

Student: mm

Patient: umm (.) and then (.) he referred me to see someone else (.) um and we saw a consultant there (.) and he did (.) different (0.5) tests (.) um (.) and he (.) basically said that he thought it was (1.5) °°haemorrhoids°° um and um and i'm back today to have a chat about what's the next step really

Student: okay (1.5) right (.) cos er what i'd like to do in our discussion if it's alright with you (.) is um (.) just start from the beginning really (.) um check that you're (.) sorry are you alr↑ight there

Patient: thhhh yeah

Student: can i get you any↑thing

Patient: no (.) no i'm alright (.) thank you

Student: alright (.) okay (.) well um just i'm gona start from the beginning (.) check that you're happy with what haemorrhoids actually are

Patient: mm

Student: and then start with what happens if you were to do nothing through to (.) the various options

Patient: okay

Student: does that sound [alright

Patient: [that’s great (.) thank you yeah

Student: so just um if we start with what haemorrhoids are >can i check< (.) what do you already know about them

Patient: um i don’t know a great (0.5) deal about them (.) i know they’re very painful

Student: mm

Patient: and they’re sort of bumpy

Student: yep

Patient: um (1.0) and a bit em°barrassing° really but that but that’s all i know

Student: mmm (.) okay (.) well um have you been told the grade of haemorrhoids that you have

Patient: um (.) yeah the um (1.5) the hospital doctor said they were grade two

Student: right (.) okay (.) if i just show you here urm i’ve actually got a picture of a grade two haemorrhoid

Patient: right (.) okay

Student: and (.) haemorrhoids are collections of blood vessels [

Patient: [right (.) mm

Student: in the back passage but there are various rea↓sons sometimes we don’t know what’s caused them (.) and sometimes if you have problems if you often have to strain if you suffer from constipation (.) you can get haemorrhoids (.) and also quite often ladies get them when they’re pregnant

Patient: right

Student: k (.) and what grade two means (0.5) is that um (0.5) whereas grade one are completely internal (.) you can’t see them

(0.5) you might be aware of some of the symptoms >but< they won't be visible or you won't be able to feel them

Patient: mmm

Student: grade two (.) they're <still within the back passage> (.) but they ss they come out sometimes and you might be quite aware of them you might feel them

Patient: yeah

Student: but they tend to go back on their own (.) does that sound familiar

Patient: yeap

Student: yeah (.) okay so um (.) with reference to what would happen if you were to do nothing (0.5) urm (.) obviously we've got to be aware that they might prog↑ress

Patient: right (.) what worse than they are there

Student: <they can do> (0.5) they might do absolutely nothing [and that's all you'll ever have

Patient: [yea

Student: but (.) but it is something that could happen they might get a little bit worse

Patient: ooh (.) i can't imagine it getting any more £worse than it is at the moment£

Student: hh okay (.) there's of course the option to do something now if you want to=

Patient: =yeah (1.0) yeah

Student: that's just if you were to keep it and then if you see the pictures progressing you reach the point where you're at now (.) they can permanently be hanging outside the back passage

Patient: ouhh right (.) yea

Student: okay (.) so um (1.0) with the di↑fferent treatment options

Patient: yeah

Student: um what have you heard so far about what you can do

Patient: uh (.) i don’t (.) i don’t know anything as yet (.) um (.) i would im↑a↓gine (.) that (0.5) there are several things that we can look at but i’m willing to try any↓thing at the moment to be ↓honest

Student: okay (.) right

Patient: because the last six months they’ve been (.) excruciating

Student: ss i can see you’re quite uncomfortable at the moment

Patient: yeap

Student: has that been causing problems

Patient: well it it is because uh we have uh a my husband and i have a business at home book binders

Student: mm

Patient: and we do some printing as well so it means i do< sit (0.5) a lot

Student: yeah

Patient: and um over the last few months i’ve been (.) um sitting on this ˚little circular cushion˚

Student: yep

Patient: which helps a bit but not um you know it won’t make em go away but it makes it a bit more comfortable

Student: mm right (.) okay and that has helped a little bit

Patient: a bit yeah

Student: okay (0.5) um (.) just for us to be aware of do you have any other worries or concerns that we need to (.) bear in mind

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Patient: _____ umm (.) well i i uh i mean my GP suggested that (.) that's what they were and i've been to the hospital (0.5) and had the (.) the tests and the:: consultant said that he thinks the same

Student: mhmm

Patient: and i think you can't help (.) worrying with something like this that (3.0) you know at the back i cc (.) i'm sure this is exactly wh-what it is (.) i'm sure it it is haemorrhoids (.) but um (1.0) but (.) tss you know all the time now there is some blood when i go to the toilet n it that is a worry

Student: right (.) you're worried that it could be something (.)[more serious

Patient: [worse

Student: well um (.) just to reassure you that um haemorrhoids is the last diagnosis (.) it wouldn't um they wouldn't diagnose it unless they'd excluded all the other [possibilities

Patient: [okay (.) right

Student: °just (.) just to let you know° (.)

Patient: thank you

Student: but um (.) if we go on to the different treatments

Patient: mm

Student: if that’s okay

Patient: mmm

Student: um (.) you can always split up the treatment ↑options to being things you can do lifestyle wise (.) um sort of minor um (.) ↑options you can take and then the surgical options

Patient: mmm

Student: okay (.) so if we start with the lifestyle options that you could do um (.) things like increasing the amount of fibre in your diet↑ could be very helpful↑

Patient: right

Student: cos as we spoke about earlier um (.) straining and um having bouts of constipation can make it worse

Patient: yeah

Student: if you increase the vegetables and (.) um wholemeal (.) content=

Patient: =that’s pretty good f-f-for me actually (.) uh uh we don’t eat meat >we eat fish< but we do eat loads of (.) veg [and stuff

Student: [right (.) okay so pretty sure you’re doing that one al[ready

Patient: [i think so (.) yeah

Student: that’s good (.) so if we move on to um (.) the interventions that we can do (1.0) there’s various things that you can try errrm such as um they can inject a chemical (.) into the haemorrhoids

Patient: ooorrhhhh

Student: which um (.) it sounds quite nasty but it's (0.5) it is done on an outpatient basis (.) it won't involve a stay in hospital

Patient: right

Student: and it should mean that um (.) quite regularly it takes care of the problem [but it it may not and we may have to try something else

Patient: [right what happens when they inject

Student: um what it does is it just causes them to shrink

Patient: oh↑ right

Student: and they'll either um come away completely or hopefully won't cause as much of a problem anymore

Patient: okay

Student: uum (.) the other option involves um cos if you see on the picture they hang round (.) hang down almost in a little sack

Patient: mm

Student: is to put a ↑band over the top of the ↑sack

Patient: yeah

Student: and what that does is it cuts off the ↓blood supply (1.0) to them to the haemorrhoid and within two or three days it should just drop off (0.5) and that will be it taken care of

Patient: m right

Student: okay (.) so that's another option (0.5) erm the ↑third sort of minor thing that we can do is to try and freeze them ↓off

Patient: (.) really like a wart

Student: yes (.) quite similar technique [to that

Patient: [˚that'd be very painful as well˚

Student: it can be quite sore but it's an option

Patient: yeah (.) yeah yeah

Student: if you didn't want to go for surgery (.) okay so if we've got those are the sort of three minor ways that we can try and treat them (0.5) or if one of those doesn't ↑work (.) or if you particularly want ↓to go for a definitive treatment (.) you can go for a surgical option [which we call a haemorrhoidectomy

Patient: [right what happens with tha↑t

Student: that is um literally going into hospital for a day maybe two and have them surgically cut away under anaesthetic (.) um a general anaesthetic

Patient: and that would mean that they're gone for good

Student: uh they can (1.0) um come back we can't guarantee that (.) obviously (0.5) we can guarantee that we can take them away at this point

Patient: mm

Student: but it's something to be aware of cos we can't guarantee that you'll never have the problem again (.) unfortunately (1.0) all we can do is what we can at the moment (.) um (.) so those are the main options (.) um (.) just so i can check whether i've explained them properly

Patient: mmm

Student: um if you were to go home um to your husband for example and explain it back to him (.) how would you explain it back to him

Patient: the op[tions

Student: [the options

Patient: um (2.0) there’s the um (0.5) the freezing

Student: °mhmm°

Patient: or the the tying they got a band round them

Student: °mhmm°

Patient: and (.) er (1.5) in↑jecting them

Student: mhmm

Patient: and the actual (0.5) proper operation where °they get them (.) ch-chop them°

Student: yep

Patient: w s it’s all a bit (.) the thought (.) is horrible (.) but i-i definitely want to have something done because i can’t i can’t carry on like this (.) i i i don’t understand wh-what’s ↓caused it though (.) in the first place

Student: it can be just be um (.) we’ll never know (.) it can be various thing that just (0.5) increase the pressure (.) um in your (.) abdomen n tummy area (.) just be the pressure has to go somewhere=

Patient: =right=

Student: =and unfortunately those pockets of blood vessels (.) just come out in order to relieve that pressure

Patient: right

Student: unfortunately=

Patient: =it’s not much relief (.) to £be honest£ .hhh

Student: what do you think of the treatment options

Patient: well (.) i definitely need to decide of something

Student: mhmm

Patient: i was hoping that there might be (0.5) something that you could say that's that and it's sorts (.) sorts it all out (.) um (1.5) i think i need to have a think

Student: <o[kay>

Patient: [maybe

Student: right

Patient: uh i i'm more inclined >even though i hate< the idea of any surgery at all

Student: mhmm

Patient: i'm more inclined to go towards something that's gona (0.5) get rid of them (.)[↑hope↓fully

Student: [okay (.) yeah

Patient: um

Student: right

Patient: i need to have a think about it and also maybe talk about um (0.5) recovery time as well (.) cos of being self-emp↑loyed

Student: yes (.) yeah (.) well with the um (.) haemorrhoidectomy >the surgery< (.) you could take more than two or three weeks it can be quite painful

Patient: mmm

Student: but (.) as i said that should be problem solved dut (.) you shouldn't have a problem

Patient: yup

Student: if they haven't been sorted at that point

Patient: yep

Student: but if you want um i’ve got some information for you to take aw↑ay

Patient: okay

Student: n if you wanted to (.) maybe go and have a think n discuss it with your husband (.) and (.) come back again n then we can

Patient: yeah

Student: make a decision

Patient: okay (.) thank you

Student: thank you very much for your time

Patient: thank you very much

Student: thank you

Participant 003

Student: hello (.) uh my name’s (0.5) kieran (.) gilroy (.) and i’m a medical ↓student (.) may i just ask you your name

Patient: um (.) it’s janice saunders

Student: °janice saun↑ders° (0.5) um (.) so (.) i have been asked to come and speak to you about your um recent diagnosis=

Patient: =yeah

Student: is that alright

Patient: that’s f↑ine yeap

Student: great=

Patient: =well my niece is a medical student actually so[

Student: [oh right↑

Patient: i understand if that [helps

Student: [very helpful (1.0) um so would you mind just sort of um filling me in as to what’s been happening so ↓far

Patient: um (.) i came to see my doctor here about six months ago (1.0) um (.) because i was really worried (.) about (1.5) the fact that (.) um i seem to be (.) um (2.0) um (.) °bleeding from the back passage°

Student: right

Patient: and erm (2.5) HE SAID that it was probably haemorrhoids

Student: right

Patient: but (.) said he thought (.) it would get better if i saw the um specialist which i have (0.5) °d-done°

Student: okay

Patient: and um (.) had some (.) tests and um had i had a sigmoid (0.5) oscopy i think[

Student: [yeah

Patient: i think that’s what it’s called

Student: yeah

Patient: and um (.) anyway consultant said he thinks (.) it is

Student: it is

Patient: yeap[

Student: [oh right

Patient: so i’m i’m just here today to sort of discuss (.) what the next step is really

Student: okay (.) okay (.) urrm (.) a::nd are you feeling okay about (.) having having a haemorrhoid (.) what do you want to (.)

to[

Patient: [well really er the worst thing for me i mean >um it is um embarrassing< it’s not something that

you[

Student: [yeah

Patient: talk about to people[

Student: [sure

Patient: and um (1.5) but the worst thing for me now in the last six months since i came to see the doctor

Student: mmm

Patient: it’s (.) it’s (.) just excruciating actually

Student: is it ˚is it˚

Patient: it <u>r</u>eally <u>r</u>eally is so i’m hoping that we can (1.0) get something sorted out

Student: okay (.) well ˚sure sure˚ it must be painful[

Patient: [mmm

Student: um (.) alright well >we’ll we’ll< really try and get something (.) sorted out=

Patient: =okay=

Student: =for you (0.5) um (.) did the doctor explain exactly WHAT haemorrhoids were and and (.) and things like that so do you understand what they are

Patient: well i’m not very clear as to what they are er er i t mean i know they’re bumps and[

Student: [yeah

Patient: and (.) and um (.) and i know they’re really painful

Student: okay

Patient: but that’s about all i know really

Student: right well um (.) what i’ll do then is just quickly (.) explain what they’re (.) sorry are ↑you are ↑you=

Patient: =yeah=

Student: =uncomfortable

Patient: i am a bit uncomfortable (.) no i just if i just
position myself or thhh

Student: sorry i should have asked before (0.5) um (.) do tell me to stop if you're (.) uncomfortable at

any[time

Patient: [okay (.) thank you

Student: i'll just quickly go through what they are (.) and we can work out (0.5) treatment options and how to decide together what would be

[best for you

Patient: [great

Student: um (.) so basically haemorrhoids are um (.) the swelling of the lining of (.) your anus (.) which is the very bottom last bit of your um your digestive tract

Patient: oh right

Student: is that [make sense

Patient: [yeah yeah yeah

Student: um (.) and anything that causes (0.5) um an increase of pressure (.) on that on on on the um (1.0) on >on a digestive tract< will result in (.) in ↓haemorrhoids

Patient: okay

Student: um so the swelling is because there's a er (.) um there're a sort of small blood vessels (.) that can become eng↑orged with blood and (0.5) that's what causes the swelling

Patient: okay=

Student: =okay[so is that is that make sense now

Patient: [well it's (.) it's interesting cos a friend of mine said she thought they were like a varicose vein but (1.0) [so it does sound it (.) yeah like yeah

Student: [yeah (.) well (.) yeah it's similar (.) and um (.) you i think have something called grade(.)grade two=

Patient: =that's what the consultant said yeah

Student: okay (.) which means that they they come out (.) um (.) but they pop back in (.) on their own so they come out when you go to the loo or something like that

Patient: yeah (.) yeah

Student: um (0.5) so in terms of things you can do to-t-to (.) in terms of treatment options (.) there are a (.) there are a few options available to us (1.0) um (.) the first thing you can do (.) yourself (.) is things ur like um er er diet (.) so (.) because (0.5) constipation and ↑diarrhoea make make it worse

Patient: and that's something that that i've tended to suffer from f-f-for quite a few years actual↑ly

Student: yeah

Patient: um (.) cos i well i think i've got IBS >it's never been diagnosed properly< but i've had it for about twenty years and at seven or eight years ago (.) >↑i think it must've been in the papers< quite a lot around that time and the symptoms were very similar to mine so

Student: okay

Patient: so i do go through times of either (1.0) y'know being really constipated

Student: yes

Patientl or the opposite

Student: yeah (.) okay (.) well both those things and particularly constipation happen when

you’re under stra:in to go to the loo (1.0) um can make haemorrhoids worse (.) so if you (.) modify your diet (.) and eat lots of fine pa::[

Patient: [yeah

Student: basically you get things moving as easily as possible (.) can help with the pain and discomfort

Patient: right

Student: um (0.5) as well as (0.5) drinking lots of fl-lots of fluid and things like that

Patient: right

Student: just to get things moving just and just to stop straining like tha::t °on the toilet°

Patient: okay

Student: that might help °on the toilet that can help° the other thing (.) which is totally non in↑vasive is is creams n you get creams just over the counter[

Patient: [mmm

Student: and they they don’t deal with the problem but they can help with symptoms (.) so they can help just um just ease the ease the pain

[and irritation

Patient: [right (.) okay

Student: um in terms of (.) um dealing with the actual ↓problem (.) are you okay there do you want me to stop

Patient: no you’re okay

Student: okay (.) in terms of dealing with the problem there are a couple of umm sort of out out patient procedures tha-that um (1.0) that tend to be done when (.) grade

(.) ur (.) ↑two haemorrhoids which is what you have

Patient: yeah

Student: the most the most common one is (.) something called a ↓band ligation=

Patient: =right=

Student: =did the doctor[mention that

Patient: [no (.) no he was a man of few words actually at the hospital

Student: okay (.) al↑right

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Patient: _____ mmm

Student: okay so would you like me to[go through that

Patient: [i'd love it (.) thank you

Student: okay basically a band ligation (.) sounds complicated but all it is (.) they it's like a like rubber band and it's under local anaesthetic so you won't be (0.5) out >you'll be awake<

Patient: mhmm

Student: urmm (.) and they just (.) put put the band um at the root of the haemorrhoid (0.5) and it should drop off basically to cut off the blood supply to that haemorrhoid

Patient: right

Student: then in two or three days it should drop off (1.0) generally a-a-a painless

procedure and it is quite is quite successful

Patient: oh okay

Student: ummm so eight out of ten (0.5) patients who who do that uurm °would be in primary care°

Patient: right

Student: okay

Patient: mmm

Student: that's the common out-outpatient procedure that we can do (.) um as an outpatient (0.5) um (.) if things progress <if that doesn't work> there are other (.) other urm (.) other procedures so we can do something called ssst ah well it's basically an in-injection of um a chemical which does the same thing >basically cuts off the blood supply<

Patient: WHAT in°to°

Student: into the into[the haemorrhoid yeah

Patient: [huuuu

Student: um

Patient: that sounds terrible

Student: it does sound terrible actually doesn't it but it's not IT'S NOT supposed to be painful (.) but it is less successful than a band ligation

Patient: ah right uh well uh (.) to be honest i'm i'm not inclined to toward any ↑surgery generally but

Student: mhmm

Patient: if i thought that it was something that would definitely (0.5) solve the problem for me i think i would consider

Student: okay=

Patient: =surgery because it’s just got so bad

Student: right

Patient: especially with work and stuff and so

Student: how has it impacted on your

Patient: well um my husband and i have our own business we’re book binders and printers (.) we work from home but it does mean that (.) i’m very sedentary actually at work

Student: yeah

Patient: and it um i’ve ended up now °°i’m sitting on this little circular cushion°°

Student: yeah

Patient: cos it’s the only wa:y i can bear (0.5) to be still

Student: yeah

Patient: so (.) and it and it is affecting (0.5) you know because it makes life so uncomfortable

Student: sure sure (1.0) so you really want to get

Patient: i really want to get this sorted out (.) yeah

Student: okay (.) well so would you be leaning towards something like a band ligation would that

Patient: well it well if you think that ↑that would be (0.5) something that would sort it out for me i’d be prepared give it a go yeah

Student: hmm yeah yeah (.)and um would ↓you err like more information on ↑sort of (.) more um invasive surgery at the moment

Patient: well if there is anything i might as well

Student: okay well well if that doesn't work and as i say it works in the vast majority of patients

Patient: mmm

Student: okay (.) but if that doesn't work there is errm more invasive surgery which would be done under general anaesthetic

Patient: right

Student: um (.) and there are various sort dif different ways of of doing it effectively (.) n the-they cut out the haemorrhoid

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Patient: _____ cuu right (.) so i bet they're gone for good then

Student: so they're they're gone for good i mean ↑both ↑both those methods would (.) would hopefully treat it (.) for good

Patient: yeah

Student: but um the more invasive surgery something called a haemorrhoidectomy which is a big word but

Patient: mmm

Student: that's urrm ef↑↑fective (.) but it's it it can be associated with more ↓pain afterward after the

Patient: which one is that one

Student: the the haemorrhoidectomy the one where you cut it out n put on a[

Patient: [yeah suppose it makes sense really yeah

Student: okay (.) so those uh those are the options really umm (.) so (0.5) does that make sense to you

Patient: yeah

Student: an-and >do you have any other sort of questions< or anything [that you'd like me to clarify

Patient: [um (.) i suppose that that er as i've been to the hospital and i've seen the consultant and he said that he thinks it is haem-haemorrhoids that that that is you know that that's what we're sort of talking about really and that that was it

Student: yeah

Patient: sort of thing

Student: y-y-yes yeah so (.) it is it is diagnosed as haemorrhoids nothing more serious °>than that<° which is [which is good news

Patient: [yeah (.) yeah

Student: um (.) you're in good company (.) fifty percent of the uk population will have haemorrhoids at some point in [their lives

Patient: [really cos you no one ever talks about it so you never (0.5) you never hear

Student: yep (.) yeah (.) well it's u awkward conversation=

Patient: =it is and everyone just laughs about it

Student: sure

Patient: and you don't realise until it gets to this point i think just how (2.0) HOW painful it is

Student: sure

Patient: and and WHY it’s so painful

Student: sure (0.5) well you are in (.) in good company and it is very very treatable (0.5) um (.) so (0.5) just to wrap up then before we run out of time

Patient: okay

Student: do you have any kind of any issues or questions that you’d like to ask

Patient: um (2.0) no i was s i was wondering why (.) y’know they’d actually come on but having talked about the IBS bit and what you’ve explained about the constipation n everything it it makes complete sense that [that would be why it’s happened

Student: [yeah

Patient: it’s just a bit scary when you >when you see< any sort of bleeding isn’t it

Student: sure

Patient: especially from the back

Student: yeah (.) okay well so the good news is that it is treatable (.) it’s (.) nothing i know it’s painful but it’s not as SERIOUS in that sense

Patient: yeah

Student: um (.) so if you’re leaning towards the band ligation (0.5) is that

Patient: well whichever is gona s-s whichever is going to ff stop it completely for me is what i’d like to do yeah

Student: well we’ll probably then from now we’ll go we’ll head towards the band ligation and ↑hopefully that will work and if not we’ll cross that bridge when we come to it

Patient: okay (.) okay

Student: um (.) so i’ll give you some more information about that and you can go away and think about it

Patient: yeah (.) thank you

Student: okay (.) thanks very much (.) good bye

Participant 004

Student: hello good afterno::on (0.5) my name’s kirsten kocik and i’m a third year medical student currently at the UE↑A (0.5) er i’ve been asked to come and talk to you about your recent problems if that’s ok↑ay

Patient: yeah that’s fine

Student: can i just check your name please

Patient: janice saunders

Student: and what do you like to be ↓called

Patient: janice

Student: that’s great

Patient: janice basically

Student: jan°°ice°°

Patient: y↑eah yeah yeah

Student: can i just check your na uh your age sorry

Patient: yeah fourty two

Student: °fourty two° and (.) um (.) so anything that you mention today will be confidential between (0.5) myself and <u>you</u> and your GP

Patient: right

Student: and please feel free to ask any questions

Patient: thank you

Student: so if you could just start by giving me (.) um the history of what’s been going on recently

Patient: um well i came to see my (0.5) um GP six months ago

Student: mmm

Patient: um because i was having (0.5) some problems (0.5) um (1.5) um (.) you know when i went to the toilet really i was really (.) uncomfortable

Student: okay

Patient: and um (.) so i came i came to see him and and um (1.0) and he (.) when he looked he said he °thought it was probably° haemorrhoids

Student: okay

Patient: um (.) but he decided that (.) it probably would best if i was referred to see someone

Student: mmm

Patient: um n and i saw a doctor at the hospital (1.0) and they did one of these um (1.0) er sigmoid-sigmoidoscopies

Student: yeah

Patient: um (0.5) and they agreed that that that's what it was

Student: mmm=

Patient: =so today i'm hoping that um (.) we'll be able to talk about the treatment really

Student: okay (.) yes certainly we'll do that (.) um (0.5) could you just tell me what it is that's mostly been concerning you about the haemorrhoids what what problem they're causing you

Patient: well (.) the last six months (0.5) it's been excruciating actually it's got to that point now where (.) th-th-the pain is (.) really awful

Student: mmm

Patient: and um (1.0) y'know i-i'm n↑ever comfortable (0.5) and um (.) and i think (.) i really think something has to be done now

Student: okay (0.5) well to be honest it is causing you a lot of [discomfort

Patient: [yeah it is yeah

Student: and i imagine that's having quite an impact on your life

Patient: well it does because my husband and i um (.) we're self employed we (.) we run a book binding (.) um company

Student: right

Patient: a-at home

Student: mmm

Patient: but of course that means i sit a lot when i'm working and and over the last few months i've actually been sitting on a circular cushion IT'S THE ONLY WAY (.) that i can be comfortable

Student: yeah

Patient: i mean it's (.) y'know (.) sometimes i stand up cos it's (.) it's so awf (.) £it's so awful£ and um it would be great if i could get back to normal

Student: of course so it's having quite an impact on your life interfering with ↑work and

Patient: definitely yeah

Student: so i can see we (.) ought to get this sorted for you um (0.5) preventing all (.) i just want to talk a bit about haemorrhoids and ↓then on to some treatment options [if that's okay with ↑you

Patient: [yeah (.) thank you (.) yeah

Student: so if you could just start by telling me what ↑you know about haemorrhoids (.) what ↑your understanding of them is

Patient: u-i don't really know very-v-very much at all to be honest now i understand i mean everyone i've spoken to n that i understand now why people are so ( ) (.) i-i-i really don't know very much (.) to be honest

Student: so if it's okay ss-um i sort of tell you a bit about them

Patient: yeah

Student: um (.) and then what sort of information do you want to get from me today

Patient: well i'd like to know what they are

Student: mhmm

Patient: and um what's caused them really (.) you know is it something that (.) that i've done my↑self or (.) or is-is it just one of those things and >and also< about what treatments there are (.) y'know can i make them go away completely

Student: yeah (.) okay so if i we should start by telling you a little bit about them n then move on to the ca↑uses=

Patient: =yeah=

Student: =then move on to discuss some treatment options

Patient: mmm

Student: um (1.0) around um your anus which is the opening of your bowel which is part of your rectum where the um faeces is stored there's lots of (.) um blood vessels (0.5) um and these become >sort of< enlarged and

um get inf↑lamed and that's what (.) the haemorrhoid is it's basically it's the bulging of this blood vessel that's surrounding tissue

Patient: right

Student: um n (.) and that can it usually happens just inside of the anus (.) and-n they can protrude out

Patient: that's that's what's happening with me

[at the moment

Student: [right (.) okay and um obviously you that it can cause pain (.) um and bleeding have you had any bleeding

Patient: yup i-uh-i almost always get some bleeding (.) not (0.5) in the toilet itself but um (.) °°y'know in the°°

Student: oh okay

Patient: yeah

Student: so again that's quite normal for the haemorrhoids (0.5) um in order words >like i said a lot of people have them< it's actually a common thing=

Patient: =no one talks about them=

Student: =no

Patient: i mean it could be unknown to people as no one discusses it

Student: that's right uh it's difficult uh uh (.) y'know (.) embarrassing to talk about

Patient: yeah

Student: um and everyone would find it hard to understand what you're going through

Patient: yeah

Student: urm (1.0) they're >they're< very common um in a lot of people (0.5) and (0.5) basically what causes them (.) um some things over the years (.) for instance like factors such as constipation (.) if you've had constipation

Patient: yeah

Student: before for a long time (.) um straining on the toilet (.) um and it can be pregnancy as well it increases the pressure around these um blood vessels (0.5) that causes them to enlarge

Patient: °ah right°

Student: so does that (.) does tha[t make sense

Patient: [u-u-it does make sense i-i-i do have problems both um (0.5) °constipation° a-and um (.) the other way actually as we↓ll

Student: okay (.) so (.) so this there is ongoing problems

Patient: for a while i think yeah

Student: and do you ever find that you have to stra↑in

Patient: i have done in the past yeah (.) yeah

Student: well these things can all (.) all (.) really contribute to the development of haemorrhoids (0.5) um and is there anything else that you'd like to know about what haemorrhoids are what causes them

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(ø) (2.0)

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Patient: _____ i don't think so >so i think basically< it's it is just one of those things really isn't it i-i think urm (.) uh i have had (0.5) trouble with my tummy for some years now (.) i think urm (0.5) that's probably why i do get constipated and and an and then i y'know i do get then i °get diarrhoea as well°

Student: okay

Patient: and so it makes sense that maybe that's what's (.) what's happening

Student: yeah (.) it seems quite likely (0.5) um especially if you've uh (0.5) had it for a little while

Patient: while before that more than ten years (.) probably

Student: mhmm (.) okay

Patient: but it's just in recent times that i've had the problems with that so

Student: mhmm (0.5) £adding to your troubles£

Patient: £yeah .hhh yeah£

Student: well um there are treatment options available (0.5) erm (.) depending urm which surgery depends on which options as well (0.5) um there's treatments that can just help towards your symp↓toms so things just like the pain (.) and then there's also treatments that aim to cure [they aim to um get rid of them[

Patient: [right
[okay

Student: um (.) what are your feelings about (.) [those

Patient:
[well (.) in a perfect world i think i'd like to cure them (.) i don't know if

that'd be possible for me but that's really what i'd like

Student: okay (.) well as far as i can discuss the the options obviously the um the ones to cure them (.) um (0.5) are possibly more invasive (.) but then obviously you've got the advantage of (.) completely curing them

Patient: mmm

Student: um (0.5) there also are some things you can do symptomatically ( ) um (.) some things that as i mentioned constipation can ca::use (.) lumps and therefore (.) helping to prevent any constipation is very important

Patient: mmm

Student: um (.) it helps t-t-twee with the symptoms and prevention in future (.) although it won't actually cure (.) the ones [that are already ↑there ( )

Patient: [yeah (.) yeah

Student: umm you can do this um by increasing the amount of water you drink (.) any drinks (.) um ↑soft drinks n ↓non-alcoholic drinks

Patient: mmm

Student: um so they'll be passed out n through and goes into the bowel and keep the stool soft as part of the

Patient: yeah

Student: um (0.5) also increase the amount of fibre so things like fruit (.) vegetables

Patient: yeah and i do take fibre gel as well

Student: okay

Patient: yeah the doctor originally gave me that because i've i've got a bit of IBS

Student: mmm

Patient: um although h-i-i that's never been (.) diagnosed i sort of realised what it was myself

Student: yeah

Patient: sort of a few years ago cos there was a lot in the press °about it°

Student: yeah

Patient: um but the doctor gave me the first one now i just buy it over the counter when i need it

Student: okay [so

Patient: [so i've tried that before

Student: and have you felt that's helped=

Patient: =i think it helps a bit but it obviously hasn't helped enough

Student: yeah (0.5) i mean that's good thing to continue doing ( ) to get between diarrhoea and constipation

Patient: mm

Student: umm so at the minute it's just a fibre diet

Patient: yeah

Student: but at the times you need it use the fibre gel so um to (.) increase the

Patient: i-i-we have a good ↑diet i mean we don't eat meat (.) we eat fish (.) we do eat lots of uh (.) fruit and vegetables (.) yes

Student: good (.) sounds like a delicious diet .hhh

Patient: £i hope so yeah£

Student: um (.) in addition to that so try not to strain a little bit

Patient: mmm

Student: if you feel the need (.) um cos that releases the pressure well it’s (.) so i suggest you try not to do that

Patient: okay

Student: um (.) in terms of (.) things you can get >you can get< c-creams you can get over the counter (.) you don’t need a prescription for them (0.5) um so they’re pain relieving creams

Patient: mm (.) right well that’d be helpful

Student: basically just rub them round the sore area and then just practically relieve pain

Patient: yeah

Student: um (.) but with something ↑else you might need from your doctor (.) is like a steroid cream if you’ve got a lot of inflammation which causes pain (.) um and that might help you (.) certainly in the meantime (.) um with at work sit down and be able to get on with your day

Patient: make it a bit easier

Student: yeah (2.0) um in terms of (.) um t-ss (1.0) curative treatments ( ) um one is that you can have an injection (.) actually into the haemo↑rrhoid

Patient: sounds a bit

Student: which always sounds a bit

Patient: that sounds ha::rsh

Student: um they’re (.) they’re very painless (.) um but that means sort of constrict it (.)

336 and (.) sort of >kill it< in a way so that
337 it falls off

338 Patient: would you have an anaesthetic

339 Student: it would be local anaesthetic

340 Patient: right okay .hhh

341 Student: £yeah don’t worry too much [won’t be left£
342 (.)

343 Patient: [.hhh

344 Student: um also another thing is like an elastic
345 band (.) tied just around the bottom of
346 the haemorrhoid and what that does (0.5)
347 is (.) cuts off the blood supply to it
348 again (.) just um just killing it really
349 so it comes off

350 Patient: oh right

351 Student: um (1.0) and um (.) that aims to cure it
352 (.) as i say another option either for
353 painful or severe haemorrhoids or if the
354 uh (.) banding hasn’t worked (0.5) there
355 is (.) the option of full surgery which
356 would be done under a general anaesthetic=

357 Patient: =what do they do with that then

358 Student: basically just cut< the haemorrhoid out

359 Patient: right

360 Student: so as i say it’s a bit more invasive

361 Patient: yeah

362 Student: few more risks with it so it’s a >sort of<
363 last option thing

364 Patient: right

365 Student: um (1.5) but it’s you know it’s worth
366 thinking things to think about really
367 looking for

368 Patient: yeah (.) so there are options then

Student: yeah

Patient: i'd definitely go for the one i think that would be the one that would completely get rid of them

Student: yeah

Patient: i think that probably it (.) even with surgery you know i'm a bit (0.5) about surgery but i think if i thought they were going to get rid of them (.) then i (.) i'd be more inclined to do that

Student: it does sound like a good idea because they're obviously impacting on your life

Patient: yeah

Student: a real impact on your life

Patient: mm

Student: y'know ff sitting

Patient: i ↑am yeah (.) yeah

Student: so it sounds like that would be a good idea for you (.) in the meantime and um t-s-s the creams might help you

Patient: mhm

Student: whilst you're waiting

Patient: mhm

Student: um and obviously we've discussed fruit

Patient: yeah

Student: and fibre gel

Patient: yeah (1.5) okay

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(ø) (1.5)

|

Student: _____ is there anything else you wanted me to talk about >anything else you wanted to know<

Patient: ur (.) i don’t think so i think that’s (0.5) i-i just wanted to get some idea of what they were and why they’re there and um what we can ↑do about them really

Student: yeah

Patient: um (1.0) so i can have a think about that before i see the doctor which will be really useful

Student: yeah

Patient: °a:::nd° (1.0) go from there i suppose

Student: yeah (.) well then um (.) good luck (.) .hhh

Patient: thank you

Student: hope you get them sorted soon

Patient: yeah (.) thank you very much (.) thank you

Participant 005

Student: hello my name’s michelle fernandes (.) i’m a fourth year ↑medical student=

Patient: =nice to meet [you

Student: [i’ve been asked to talk to you to↑day

Patient: okay

Student: okay can i start by asking you your ↑name please

Patient: yeah i’m jamie s-s (.) jamie saunders

Student: and how old are you↑

Patient: fourty [two

Student: [fourty (.) okay is it alright if i call you jamie=

Patient: =please do (.) yeah

Student: okay (.) so (.) if you’d just like to by telling me (.) uh what’s been going on

Patient: uh (0.5) well (0.5) i’ve got quite a lot of (.) discomfort in my back passage (.) basically

Student: mmm

Patient: and uh (0.5) i’ve had it assessed now by the consultant (.) urm (.) who seemed to think it was (0.5) haemorrhoids

Student: okay

Patient: um (.) it’s (.) it’s been very frustrating for (.) a while now and it’s been particularly bad the last six months

Student: mhmm (0.5) so you’ve ↑had it for longer than six months

Patient: YEAH i first came to (.) came to the GP six months ago but obviously i (.) i've been having trouble for (.) for a while now (.)and um i mean i've got IBS you see and um

Student: °okay°

Patient: had that maybe for about eight ↑years or something

Student: mm

Patient: uh (.) and that's (0.5) that's enough in itself but then to have this as well you know and it's all quite embarrassing °you understand°

Student: hm well there's nothing to be embarrassed about really

Patient: [hhhuhff

Student: [um how's it affecting you day to day

Patient: well the trouble is um (0.5) i sit down a lot in my job you know and it's it's i actually have to sit on a cushion now and i'm fourty two i don't want to be doing this um (1.0) but er you know i'm self employed and i i do have to sit down a lot while i'm working

Student: mm (0.5) what do you ↑do

Patient: i'm actually a-a book binder

Student: okay

Patient: yeah (.) so i got i mean i (.) it's great in some ways it's work i love to ↓do

Student: mhmm

Patient: but um (1.0) you know i-i work from home and er (.) i work with my partner but >it's just it's just< really affecting me quite badly it's um

Student: mmm

Patient: quite demoralising you know

Student: yeah i can i can see that you you don’t seem very (0.5) you seem kind of (.) fed ↑up with it ↓all

Patient: well yeah i mean if i could just get it sorted out once and for all that would be (.) such a relief you know i’m just

Student: mmm (.) have you tried any things though to help the haemorrhoids

Patient: well um (.) when i get the IBS badly i (.) um (1.0) take fibre gel

Student: mmm

Patient: bought some other (.) y’know thing from boots depends what’s (.) i just try these different things n that (.) it helps a bit with the sort of constipa:::tion and and (.) and er diarrhoea and so on

Student: mhmm

Patient: but um (.) nah i mean it’s (0.5) nothing’s really dealing (.) with it

Student: mmm

Patient: i mean it p-perhaps it’s because i sit down a lot of the time >i ↑don’t ↑know<

Student: well you you mentioned to me you you had IBS for a very long time and

Patient: about eight years i think (.) i mean i decided that was what the problem was when i (.) it was just suddenly i became aware of it it was all over the internet and everything and

Student: okay

Patient: and i just sort of thought yeah >that’s what i’ve got< (.) y’know

Student: mmm

Patient: i asked the doctor around the time (.) n he sort of confirmed that

Student: mm (1.0) and um do you get very constipated with that

Patient: y-yeah you get both really (.) you get constipated you get diarrhoea >y'don't know< what's going to happen next

Student: yeah

Patient: um (.) it sort of (1.0) it can be >it can be very troublesome if you want to go somewhere you've got to know there's a toilet nearby<

Student: mm

Patient: and other times you get constipation so

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(ø) (2.0)

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Student: _____ <y[eah>

Patient: <[yeah>

Student: and um (.) in terms of the (0.5) actually take some things specifically for the haemorrhoids have you tried anything at all

Patient: not really no

Student: no=

Patient: =no

Student: are you aware of any (.) uh topical creams you can use that you can get from your ph↑armacist

Patient: urm (.) i-i haven’t done that ↓yet (.) er but if you recommend that then

Student: well there are several things you can try out there just (.) over the counter medications

Patient: will it really help i mean (.) will it make them go or

Student: um i-it it’s not really to (.) it doesn’t treat the <cau::se> of [them

Patient: [no

Student: it’s more of um (.) you know uh just a symptom (0.5) relief

Patient: okay

Student: can (.) can help for a while (.) but (.) as you have IBS you your constant-constipation (.) having to strain is what really causes the haemorrhoid so you’re very right in in trying fibre gel ( )

Patient: do you think i should ↑just (.) take it all the ↑time

Student: um (.) it’s not necessary unless you you feel constipated at the time (0.5) it’s not gona (.) it’s not gone it’s not a ↓cure really (.) yeah

Patient: right (1.0) i mean (.) is there something that (.) i-is there a cure i mean

Student: for the haemorrhoids

Patient: yeah

Student: um (.) you can have surgery but that would (0.5) really be a last (.) y’know resort so

Patient: d’you (.) but if it would sort it ↑out i would definitely con↓sider it

Student: yeah that's something that you can bring up with the (.) with your GP

Patient: yeah

Student: uh together with how (0.5) obviously it's affecting your life (.) and your (.) your work as well (1.0) [maybe

Patient: [i-i'm quite (.) yeah yeah yeah

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(ø) (1.0)

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Student: _____ are you working nor↑mal hours have you found that you have to (.) er work less now

Patient: uh-t (.) if the work's there you just have to do it y'know i (.) i'm quite fit i like walking around a lot as well it's not like i just sit all day (.) but um (1.0) yeah (1.5) it's quite i'm quite concerned about it the fact that it's carrying on y'know

Student: mmm

Patient: i've still got it (.) do you think it's because i've got IBS you think that's (0.5) what you ↓caused it

Student: well that the (.) the cause of haemorrhoids is (.) you know extra pressure (.) you know down there and it causes the the the blood vessels to bulge out

Patient: right

Student: erm just under the (.) the force of obviously having constipation and having to strain

Patient: [yup

198 Student: [um (.) when you go to the toilet so yeah
199 that could be uh that could be the reason

200 _____

201 |

202 (ø) (2.0)

203 |

204 Patient: _____ you don’t think it’s anything else
205 (0.5) ↓causing (1.0) ↓problems then

206 Student: um (.) have you had any (.) obviously
207 you’ve got the IBS but have you had any
208 (.) more recent changes in your bowel
209 habits at all

210 Patient: um (.) this (.) um quite often blood in
211 the toilet bowl

212 Student: okay (.) and is it er fresh blood <or> is
213 it mixed in with the ↑stool at all or

214 Patient: no it’s just on the paper

215 Student: okay

216 Patient: yeah

217 Student: well that’s very likely to just be blood
218 from the ↓haemorrhoids

219 Patient: right

220 Student: um but i can understand why you’d be
221 concerned about having blood in your stool
222 so again and we’ll see what we can do (
223)

224 Patient: okay

225 Student: if we need to have further investigations

226 Patient: right (1.0) but what would they before if
227 they (.) if i had them

228 Student: um further investigations

229 Patient: yeah

Student: well it could be a number of things (.) obviously most likely is the haemorrhoids since you have haemorrhoids (.) um

Patient: i mean i had a camera put up there y'know

Student: mm (.) and ↑when was that

Patient: yeah that was when i went to see the consultant (.) it was a couple of weeks ago

Student: okay (.) and um have you had the results back

Patient: yeah yeah i'm gona just said (.) just say it's grade two haemorrhoids

Student: yeah well it's unlikely to be anything (.) more sinister (.) um (0.5) they've investigated and (.) and you're fit and well in yourself aren't you

Patient: yeah i mean y'know i say i like (.) like i say i'm quite active really i like long walks and i'm (.) i-i'm mostly vege↑tarian ↓y'know

Student: yeah

Patient: i just eat fish and veg n er

Student: yeah (0.5) that's good (.) i don't think you have anything (.) anything really t-to worry about (.) y'know try (.) try some topical creams see if those help at all (.) y'know make you more comfortable and um=

Patient: =okay

Student: definitely speak to your GP

Patient: is is it just really either the the creams holding it back a bit or surgery that's all i've got is it

Student: well y-you can try the things you're already doing to stop the constipation

stop the (.) the haemorrhoids forming in the first place ˚yeah˚

Patient: yeah

Student: your haemorrhoids are grade two they're not the most severe ones

Patient: no

Student: so there's (0.5) uh the GP would be more likely to want to manage you without surgery ↑really

Patient: right (0.5) okay

Student: yeah

Patient: so just like (.) ↓carry on then

Student: well (.) yeah (.) i mean (0.5) there are other things that we haven't yet tried (.) so (.) it's not (.) you haven't come to the ↑end of the >y'know< tunnel yet in terms of things you can do for yourself (.) to make it easier for you to live your day to day life

Patient: yeah

Student: are you still able to go for long walks and (.) and do the things you want

Patient: well y'know if i haven't got (.) if the IBS isn't playing up ↓yeah ↓yeah i like to <walk around> norfolk y'know (2.0) the coast and things

Student: so as long as you (.) stay active and (.) y'know do the things you want to do (.) don't let it (.) stop you (0.5) y'know living your day to day life

Patient: kay

Student: yeah (.) and and you s-s you mention that you're sitting on cushions uh (.) is that helping [support it

Patient: [well yeah i mean it s-stops the pain at the time but i suppose (.) sitting down a lot doesn't really help the condition either does it

Student: yeah well (.) you don't really want to be sitting down when you're uncomfortable down there ↑do you

Patient: ↓no (.) maybe i'll just have to figure out some way of standing up more though

Student: well you're qui-you're quite lucky in that you work at home n n you can [keep your hours more flexible

Patient: [sure hmm (.) okay (.) okay

Student: are there any questions that you want to ask me at ↑all

Patient: um (.) no i think that's it actually

Student: mm (.) so just to review what we've talked a↑bout (.) um you've been having the haemorrhoids are they've been particularly bad (.) since the last six months

Patient: they have yeah

Student: um affecting your work and you're having to sit on cushions (.) and we've discussed that ther-there's over the counter things that you can try (.) um to maybe (.) help relieve the the discomfort (.) um and you're worried about some blood (.) um in the toilet though that um (.) we've discussed this and it's unlikely to be anything (.) um other than the haemorrhoids but um you're gona have a word with your GP

Patient: okay

Student: so

Patient: yeah

Student: just to reassure yourself (.) um (0.5) and (0.5) um is ↑that ↑everything

Patient: um (.) yes i think so (.) yeah (.) thank you

Student: thank you

Participant 006

Student: hi mr sa↑unders

Patient: hel[lo

Student: [thank you for coming in to↑day

Patient: no you're welcome mm

Student: um my name's daniel fox i'm a (.) ↑third year medical student from the university (.) and uh your GP (.) er who you've come in to see today just asked me if (.) i could sort of talk to you first to discuss some ↑of the (.) um sort of (.) some of the inf-information with you >before you see him<

Patient: ye ah mean my (.) my niece is at uh (0.5) durham doing ff her her first year of medical=

Student: =ah right (.) excellent

Patient: training in that she says it's really helpful to talk to patients so

Student: yeah >well if that if that's still okay with y[ou<

Patient: [>YEAH OF COURSE YEAH< yeah of course yeah

Student: and ur hopefully i can sort of (.) help to explain a few things for you n then if you think of anymore questions n you can still sort of talk about to the GP afterwards

Patient: °okay yeah°

Student: so um (.) if i could just >sort of< start um (.) could you sort of tell me what's been going on so far and >sort of< what you know all re↑↑ady

Patient: um (0.5) yeah i mean (1.0) er basically i went to the doctor (.) six months ago (.) because i had some bleeding from my back p-passage

Student: mm

Patient: um (0.5) and (0.5) i mean hhfff (.) it's been u-fairly long running now >i've had IBS for< twenty years or so (0.5) as it seems now *cough* anyway he sent me off to see the specialist and (.) um (.) so it all went to colorectal (0.5) clinic and er (.) they had a (.) y'know (.) sigmoidoscopy >°so it° and er< (1.0) the er said it's sort of grade two (.) haemorrhoids

Student: mhmm

Patient: °°so yeah°° um i'm just (.) now it's just so bad i just really want to get it sorted out

Student: yeah of course (.) i can understand that (.) yeah (0.5) so yeah >so i mean< it's already been it's already been going on quite a long while (.) >you've been through quite a lot already really h[aven't you<

Patient: [well yeah (.) i mean the IBS is bad enough n then for it (.) i mean hhhfff (.) i don't know why °i thought° i suppose they might be (0.5) connected uh (0.5) the two things (.) sort of (.) haemorrhoids and (.) and um (.)IBS

Student: mmmmmmm (.) possibly yeah and we can talk about that (.) if that's >tur-ur-something< you're intres-interested in

[>n then we go back<

Patient: [yeah

Student: so um (.) so yeah (.) so really it's >yeah so i can see you're had this of course and

of course< the bleeding must be quite worrying for you as w[ell

Patient: [yeah (.) very worrying [yeah

Student: [yeah (1.0) so uh (.) what do you understand about haemorrhoids >have they explained anything to you alre↑ady< (.) about what they actually are↑

Patient: ˚they said it's˚ (.) something to do with um (.) sort of st↓raining when using the toilet and things (1.5) um (.) i think i mean YA KNOW i-it is quite bad (.) sometimes (.) it seems to sort of (.) project out y'know (.) ˚the back passage˚ and uh (.) yeah (.) it's very painful

Student: of course it all sounds very unpleasant (0.5) particularly with the IBS as well (.) so um (.) >so what are the main< sort of things that you would like to know a bit more about to↑day

Patient: well i-i mean ther-there's↑ (0.5) uh (.) w-why i have got them y'↑know i mean the consultant was a bit (0.5) brisk y'↑know

Student: yeah

Patient: urm (.) so i-i-i just wana know (.) i s'pose why (.) i might have them >if there's anything i can do for myself<

Student: yeah sure

Patient: um (.) and i-if i can just get rid of them (.) y'know (.) i-if even if it's something quite drastic (.) i'd (.) i'd be considera y'know (.) bup (.) prepared to consider that now

Student: okay ˚certainly˚ (.) yeah so then >s-sort of< (.) what you're sort of giving me there (.) is if we talk a little bit about (.) >sort of< what they actually are (.)

so terms like (.) so though you've been given an idea (.) you haven't been explained that clearly (.) and then ss (.) what sort of things you can do to try and help >sort of< (.)[for yourself

Patient: [yeah

Student: and then we're gona look at some of the (.) the treatments that (.) we can offer you or the (.) >y'know< that you might have to g-go out to the out-patients back there again to be offered (0.5) does that sound reasonable is that the sort of things you'd like to cover

Patient: yeah (.) and i mean i (.) I S'POSE i am quite worried about >sort of< bleeding from down there

Student: yeah of course (.) yeah

Patient: i mean it could be anything °couldn't it°

Student: yes it can but hopefully yeah i can talk a bit more about bleeding as well and hopefully reassure you about that (0.5) okay °°then°° so just to start with about what haemorrhoids are >this sort of ties in with the bleeding and symptoms as well< so as i've said (.) they are related to straining but >i mean< that's not entirely (.) well not exactly what causes them (.) if you think about um sort of around your back passage (.) there's >sort of< veins normally lie around your back passage

Patient: mm

Student: and um these are sort of present (.) well i'll show you on this diagram here (.) so what happens is (1.0) these veins normally sit around (.) the back passage (.) uh they're quite thin and they don't cause any troubles (.) but (0.5) what you can get is for some reasons and IT'S NOT entirely this but it relates to things

like straining and constipation (.) if there's a lot of pressure on these veins they can sort of swell up↑ (.) and sort of fill (.) um and so that's and because you've got these swollen veins they can then project (.) >sort of< into your back passage (.) and if you've got these swollen veins projecting into the back passage (.) that could mean you can then sort of y'know you can be aware someti sorry could be aware sometimes of a >sort of< a sort of throe feeling in your back passage because they're pr they're protruding into it (.) or you sometimes get the bleeding (.) and so >sort of< y'know it's alright to say especially now is that (.) this is the bleeding you've been having (.) as what type of bleeding you've been having and (.) y'know they look with a scope (.) so they know that's it's not s-from anything higher up (.) the bleeding you've been getting is purely due to these sort of veins (.) n because these veins are >sort of< sticking out your back passage (.) as you (.) as you open your bowels (0.5) sometimes that causes veins to all be damaged and >sort of< blood [leaks out

Patient: [it's more fragile is it

Student: exactly yeah so↑ all that's all that's so the bleeding you're experiencing is simply because of these (.) these >sort of< (.) swollen FAT veins being >sort of< NICKED (1.0) as the as the >sorry< food goes past essentially [and that causes a bit of blood loss

Patient: [right yea (.) right

Student: um (.) so the blood loss is only from ch veins cos they're dying each time it happens n they >sort of< they heal up again (.) >so that< so it's nothing

nothing more sinister than that that's the reason your GP sent you to have (.) the um

Patient: right

Student: have the (.) sort of scope to look up there=

Patient: =so you're sure it isn't anything else °°more serious°°

Student: no no °no° that's why >so with-with the< scope they will've (.) um >y'know< if they didn't explain this to you at the time (0.5) they look sort of right round the back (.) because of course i mean you can imagine you perhaps might be concerned that it could be <cancer> or something like that

Patient: yeah well my (.) my dad (.) had bleeding from his back passage

Student: oh i see

Patient: and it turned out to be bowel cancer (.) and (1.0) er he had a whole kinda um y'know (.) colonoscopy n (.) he died °another° eighteen months later

Student: sss i'm very sorry to hear that

Patient: yeah it's (.) it was a while ago but obviously (1.5) huh (.) you just don't know do you (.) i-i i don't know ( )

Student: no (.) course no i mean i'm really sorry (.) and when you've had a tragedy like that in your family that can (.) really sort of play on your mind as well that [can as well

Patient: [yeah (.) yeah

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223 Student: _____ um well one thing i can say
224 sss today is that (.) >y'know< it's very
225 reassuring that you've >y'know< that
226 you've had you've had the scope done (.)
227 you've had the report come back from the
228 consultants (.) and they're (.) they're
229 very happy that this is simply the
230 >bleeding is< simply due to a ↓haemorrhoid

231 Patient: right (.) [↑okay

232 Student: [so it's (.) it's external
233 bleeding rather than anything internal or
234 anything to worry about

235 Patient: yeah

236 Student: so i can definitely >y'know< reassure you
237 about <u>that</u>

238 Patient: thank you

239 Student: and an-and th-th sort of (.) really this
240 concern shh we met before is (.) the fact
241 you've had someone in the family like that

242 Patient: yeah you (.) [you'd think wouldn't you

243 Student: [because that's very worrying
244 (1.5) but yeah so (.) um so just sort of
245 going on so t-the haemorrhoids are usually
246 caused by >as i've said< so far (.) the
247 st<u>rai</u>ning (.) and >sort of< things like
248 constipation (.) so that could be one of
249 the link with your IBS (.) because um (.)
250 if your IBS causes you to a bit
251 constipated at times (.) because=

252 Patient: =it >do-e er um y'know< it's constipation
253 one minute and (.) diarrhoea the next=

254 Student: =exactly yeah (.) so (.) if you've got
255 these hard stools now and again (.) then
256 those can <u>again</u> cause these haemorrhoids
257 to form <and also> cause them to bleed a
258 bit when you pass a >sort of< hard stool

as well (.) so that could >y'know< that could be the link there perhaps with your IBS and sort of as you (.) as you rightly (0.5) pointed out there could be an association between the two (.) ummm (.) and that's the main thing with these with the haemorrhoids (.) and so they can come in (.) every-ff (.) i don't know if you've been told (.) have you ever been told that your haemorrhoids are a particular gra↑de (.) [at all

Patient: [he said they were grade two↑

Student: okay

Patient: is that very bad ↑or

Student: um (.) eh-h-h sort of what happens is (.) >with haemorrhoids< (.) um they class them as grade one to four

Patient: right

Student: so grade one are just >sort of< small haemorrhoids that uh (.) are up in the back passage n that you can't (.) they don't >sort of< protrude (.) obviously that you can see >but they might cause of arh bleeding now and again<

Patient: right

Student: uh grade two which is what um (.) haemorrhoids that you've got (.) are slightly larger >and so< these ones might >sort of< protrude (.) sometimes

Patient: right

Student: particularly when you pass a stool (.) and then but they go back up spontaneously (.) so if they do protrude >they they< go back up spontaneously

Patient: right

Student: um (.) so you'll be >sort of< aware of them

Patient: yeah (.) that's r[ight

Student: [but then they disappear again afterwards

Patient: yes they do (.) yeah

Student: °yeah° (.) and then the next >sort of< two grades off that which °are sort of° the more severe ones are >sort of< grade three where they (0.5) prola-they come down sorry but (.) >sort of< they don't (0.5) retract spontaneously (.) so you have to sort of (.) you can manually put them back (0.5) and then grade 4 are down all the time potentially

Patient: yeah=

Student: =so so these the grades do >sort of< correspond to severity so GRADE TWO is >sort of< it's sort of in the middle but it's not it's not majorly severe

Patient: no (0.5) but i'm likely to get ↑worse i suppose ↑am i

Student: they (.) they (.) sometimes they're progressive at times sometimes they sort of stay the same (.) so i mean that's why there ([ )to treat it

Patient: [okay (.) yeah yeah

Student: so um (.) i know i explained a lot to you there

Patient: mm

Student: has everything that i've said so far (0.5) ↑made ↓sense (.) is th[at

Patient: [no no it's very clear thank you

Student: did you have any other questions about that

Patient: um (.) well no i suppose just (.) what can be done then really y'know [or or

Student: [okay

Patient: i mean i have to sit down a lot a-at work i mean is that making it worse then do you think

Student: ummmm (.) possibly but not necessarily so-s-sort of some of the things that's s-sort of going on is so things that you can now do (.) some of the things that you can then do (.) a::re >sort of< um trying to (.) ensure that you've got plenty of fibre in your diet

Patient: right

Student: and also lots of water (.) cos these things help make the stool softer

Patient: right

Student: so they >y'know they if you've< if you're passing softer stool if you're not constipated (.) if you're not straining (.) at the toilet (.) then your less likely to cause damage to the haemorrhoids and the haemorrhoids should (.) >sort of< improve as well (.) so y'know making sure you've got plenty of fruit in your diet

Patient: mmm

Student: brown bread rather than white bread things like that (.) so that those can all help (0.5) umm and then water so yea so it's y'know they talk about (0.5) how many litres you drink a day but (.) you do want to >sort of< be ( ) on the side of more rather th[an less

Patient: [i steer clear of brown bread actually (.) i think it’s not (.) doesn’t really suit me ˚too much˚

Student: okay (.) so does that >sort of< affect your IBS

Patient: yeah

Student: ˚ah right˚ well if that’s not something you can manage then (.) um you can >sort of< (.) >fruits and vegetables< and what we can do is (.) if you’re finding it hard to >sort of< get enough fibre in your diet (0.5) then (.) um (.) you can also take some fibre [supplements

Patient: [take some fibre gel=

Student: =oh you have [taken it be↑fore

Patient: [yeah i take it sometimes

Student: how do you get on how do you get on with that

Patient: s’alright s’not much fun to take it but i’ll take it if it helps (.) you know

Student: ˚˚okay˚˚ yeah well it certainly it would help and particularly if you find that you’re (.) struggling to get enough fibre in your diet then sometimes to have a bit of extra fibre can be quite useful

Patient: well yeah (.) i don’t eat meat you see i just have (.) i-i have fish and vegetables n that (0.5) so you’d think that my diet wasn’t too bad=

Student: =ttt no it sounds like you’re getting a reasonable amount of fibre into it so that’s a good thing

Patient: i know

Student: so those are >sort of< some of the basic measures you can take (.) another thing is (.) as we’ve said because it’s very

unassertive to put strain on (.) you want to try and avoid strain (.) so try not to spend >sort of< too long on the toilet and just to try and go regularly and the way you need it not to hold onto it (0.5) so y'know if you can reduce the strain that will also reduce all the pressure (.) and so that the pres the pressure in the back makes it worse

Patient: mmm

Student: so these are all things that you can do yourself (.) um i know that >sort of< you you mentioned you wanted a solution and you wanted to look at >sort of< um (.) >sort of< more (0.5) long term (.) yss more (.) permanent treatments

Patient: yes yeah

Student: so there are a few things that can be offered if you finding that these (.) conserva ur >sort of those measures last time they just aren't helping< (.) so the first thing is (.) um (.) is um i mean there's quite a few different treatments and they're all sort fairly >sort of< equally effective (.) so one thing they can do is (.) um >sort of< an injection (.) and as i say an injection into the haemorrhoid (.) which causes them to >sort of< it's called sclerosis <°treatment°> and what it does is it causes the haemorrhoid to >sort of< retract (.) and harden an-an- and then (.) sort of go away

Patient: oh right

Student: so that's >s-sort of< that's an injection that you have into the haemorrhoid (.) another thing that they can do is called banding which essentially where they put like >a ss-sort of< rubber band around the haemorrhoid (.) like uh zzz earlier that causes the haemorrhoid shhht to >sort of<

439 die and then fall off (.) and then that
440 clears the haemorrho[id as well

441 Patient: [yeah

442 Student: so that’s there’s sclerosis there’s
443 banding (.) also they can (0.5) clear the
444 haemorrhoids with something called
445 infra↑red (.) which is sort of (.)
446 essentially they’re just sort of (.) um
447 (.) they hit th-um (.) they s-sort of zap
448 the (.) haemorrhoid with the (
449)n that causes them to (.) clear up

450 Patient: right

451 Student: and and sort of and sort of (.) retract
452 and go back so that can clear them (.) and
453 then also either they can use the heat of
454 the infrared which is >sort of< heat
455 treatment or they can use (.) the opposite
456 as it were which is (.) called cryotherapy
457 and that’s where they freeze the
458 haemorrhoids (.) and again by freezing
459 them the haemorrhoids will then (0.5) the
460 tissue will die and fall off and that
461 again gets rid of the haemorrhoids

462 Patient: right

463 Student: so those are four main options (.) and
464 then the >sort of< the final option is
465 surgery to s-s-surgically remove the
466 haemorrhoids

467 Patient: yeah

468 Student: um (.) and >sort of< each of these has
469 their own >sort of< pros and cons [in (
470)

471 Patient: [sure

472 Student: so those are the five main treatments
473 (0.5) k if you’re happy with those (.)
474 ummm just to quickly >sort of< look at the
475 pros and cons °i mean° all of them (.)
476 sometimes with the-the banding and the

>sort of< infrared you may have to go back for more than one treatment (0.5) i don't know if that would be an issue wisss work °n things°

Patient: well i'm self-employed but y'know if we're busy obviously it's (.) hhfff quite inconvenient (.) but then it's (.) very uncomfortable at the moment for me to uh y'know i'm sitting on a cushion basically to get my work done

Student: °of course° so you need something more ( )term more long term [yeah

Patient: [i do (.) well (.) i- i'll try anything [really i'm getting quite desperate

Student: [yeah (.) well i say >sort of< those four treatments are normally effective (.) one thing i would say s-s-surgery isn't really recommend wouldn't really recommend that unl[ess they're sort of

Patient: [no (.) unless they're really bad

Student: really severe ones (.) because the thing with surgery is (.) it's quite (.) y'know (.) sort of (.) it's not ( ) enough to go down the route of general anaesthesia and you're likely to need a week or two off work (.) particularly for yourself being self-employed

Patient: yeah yeah

Student: that's not really something that you'd probably want to consider anyway

Patient: it also sounds quite painful it sounds more painful than having an injection or something

Student: it could yeah it certainly could potentially be painful and then there's

515 >sort of< risks that you always have with
516 surgery perhaps bleeding or infection
517 afterwards so

518 Patient: yea okay

519 Student: so perhaps the better option for you would
520 be one of the other four

521 Patient: okay

522 Student: o↑kay

523 Patient: yeah

524 Student: so um (.) i think we're >sort of< running
525 out of time n you need to see the GP so
526 just to summarise (.) um what we've talked
527 about so far and then i can leave you to
528 think about that (0.5) so jssts
529 haemorrhoids are essentially are these (.)
530 swollen veins that can get damaged (.) as
531 you're passing a stool and that's why you
532 get the bleeding but there's no other
533 >sort of< more sinister reason for that

534 Patient: right

535 Student: in your case (.) they can go from grades
536 one to four as we've said you've >sort of<
537 got grade two haemorrhoids which is >sort
538 of< in the m↑iddle (0.5) and then some
539 things that you can do for yourself is the
540 fibre (.) water (.) um trying not to
541 strain your stools (0.5) and then >sort
542 of< the few treatment options that we
543 discussed (.) are the ss-rubber banding
544 (0.5) the infrared (1.0) <the> >sort of<
545 injection

546 Patient: yeah

547 Student: and °the° cryo (.) n then >sort of< then
548 the surgery which is perhaps more a last
549 re↓sort

550 Patient: sure

Student: n that’s something now you can discuss and have a think about what option would be best for you

Patient: alright

Student: so i hope that’s been helpful

Patient: yeah very helpful (.) thank you

Student: >thank you< do you have any last questions for me at all

Patient: no i don’t think i think you’ve covered it all thank you

Student: okay thank you very much

Participant 007

Student: hello (.) um (0.5) is it mrs sa↑unders

Patient: yes

Student: hi i'm alice alden >i'm one of the fourth year medical students< n the doctor's asked me to (.) come and have a (.) chat with you today if that's okay

Patient: yeah that's fine yeah

Student: so everything we talk about's confidential (.) um [if you want to stop or if you've got any questions just let me know [that's fine

Patient: [°°great°° [oh okay yeah

Student: are you sitting there comfortably

Patient: i'm not very comfortable (.) but i'm okay yeah=

Student: =i understand you've come in to talk about your (0.5) haemorrhoids

Patient: uh yeah treatment hopefully yeah

Student: okay so do you want to just tell me a bit about what's been happening with them and (.) and where we are now

Patient: um (1.0) well (0.5) sort of for years on and off i've (.) y'know (.) i've had um (.) >sort of< (1.0) tummy problems and it's been a bit sore (.) and=

Student: =right

Patient: um (1.0) but in the last six months um (0.5) the pain actually has been excruciating

Student: okay

Patient: um i came to see my GP (.) um °six months ago°

Student: right

Patient: and um (0.5) and then eventually i went to the hospital

Student: yeah

Patient: um (.) and they did this erm (0.5) sigmo::idoscopy

Student: mhmm

Patient: um (.) and er (.) >the the< the doctor at the hospital said (.) they were haemorrhoids

Student: okay

Patient: and um (.) but it has got to the point now where it's really really painful

Student: i um (.) yeah i can imagine it's not a very nice (0.5) thing to have so (.) and now you're thinking about the next step for (.) some sort of treatment is that right

Patient: i hope so yeah

Student: um (.) is that what you've come in to talk about (.) today

Patient: yeah (.) yeah

Student: have you got any ideas in your head already about what kinds of (.) um treatments you might have

Patient: I DON'T KNOW i mean (.) well (1.0) what i'd like is (.) something that will (.) make them go away (.) that in in a perfect world [that's what i'd really like but i don't know what (.) what you can advise me of (.) really

Student: [yeah okay (.) well um if it's (.) if it sort of suits you i'll (.) i've

had a look at your notes so i think i'm (.) right in saying >you might not understand this but< grade two um haemorrhoids

Patient: well the doctor at the hospital (.) mentioned grade two

Student: okay (0.5) um so there are some >sort of< um (0.5) treatments that are um (.) that we use for grade two and if (.) it's okay with you i'll talk to you about those

[and then you can (.) see which you think might be good for you

Patient: [yeah please (.) yeah

Student: so um (1.0) as you said yeah (.) they're grade two haemorrhoids (.) ↑do you know what haemorrhoids actually are

Patient: not really

Student: would you (.) would it be helpful for me to explain [quickly about them

Patient: [yeah please yeah

Student: i mean (.) they're basically um in your anus there's it's quite vascular that means there's a lot of kind of blood supply and

Patient: right

Student: um (2.0) sort of things going on there (.) and sometimes um you get a little what we call out pouching (.) of the lining (.) round there (.) and that's what the haemorrhoid is >it's a little out pouching< um of the normal (0.5) um structure (.) the normal >sort of< lining of the anus (.) and um (.) and it just (0.5) um (0.5) sometimes falls down which is when they (.) come out

Patient: yeah

Student: i don’t know if you’ve ever experienced
[that

Patient: [yeah yeah

Student: and then obviously because that’s
happening that can be quite (.) painful
and as you’ve (0.5) got pain

Patient: yeah

Student: um that’s ˚that’s probably the reason˚
(0.5) so um (.) as i said there are
various things we can (.) try with
treatment (.) um (.) we’ll start off with
the most basic things and (.) go on from
there

Patient: yeah

Student: so um (1.0) the first thing that they
recommend is (.) um >sort of< dietary
↑↑modifications

Patient: right

Student: um they thhhink that um one of the reasons
that people (0.5) get um haemorrhoids or
that some people are more susceptible to
getting haemorrhoids (.) is if they’ve had
constipa[tion a lot in the past

Patient: [yeah

Student: y’know had to strain a lot when they go to
[the toilet

Patient: [yeah

Student: is that something you’ve

_____

|

(ø) (1.0)

|

Patient: _____ yeah (.) i've i've (.) i've had (.) um IBS (.) um i would say y'know (.) well (0.5) for the last >sort of< ˚twenty years˚ i (.) it was ↑only (.) i-in recent years that i decided that's what it was be:cause there was a lot in the papers and on television about it about eight years ago

Student: mm↑m

Patient: um (1.0) and i s-s-suffered with tummy cramps (.) and (.) um and that's what um exactly what happens to me that i go through (.) times of being constipated but then i i also (.) um (0.5) have the opposite when i'm (.) um (.) y'know (.) it's like it (.) well ˚˚˚it's like diarrhoea really˚˚˚

Student: right

Patient: so it can go either way

Student: okay

Patient: yeah

Student: um and (.) what have you done in terms of treatment for your (.) [IB IBS

Patient: [well i came to the doctor at the time and um (.) the doctor has prescribed me fibre gel

Student: okay=

Patient: =in the past

Student: oh okay

Patient: um (1.0) and what i tend to d-to do now cos >i don't need it all the time< i just i-i buy it over the counter when (.) when i need it

Student: and you find it helps

169 Patient: i think it does help a bit but obviously
170 (0.5) the damage has been done really i
171 think

172 Student: okay=

173 Patient: =yeah

174 Student: so those are the sorts of things with that
175 whole IBS thing that we talk about in
176 dietary modification

177 Patient: mmm

178 Student: so making sure you have lots of (.)
179 <water> um eating like fibrous vegetables
180 and fruits and obviously your fibre gel

181 Patient: yeah

182 Student: just to help the stools be more formed so
183 you don't have to strain as much

184 Patient: yeah

185 Student: but as you say (0.5) um (1.5) the damage
186 has already been done we don't (.) but (.)
187 again (.) we can't °like° (.) we can stop
188 them from getting worse ( )

189 Patient: yeah

190 Student: so that so that's one option the next
191 thing is um (.) we can (.) give you creams
192 that you can apply to the area (.) um that
193 help to keep it (.) um (.) will help to
194 prevent some of the pain and keep it like
195 nice and (0.5) um (.) um sort of a bit
196 more (.) er lubricated [if you like

197 Patient: [yeah (.) yeah

198 Student: i mean some people find them quite helpful

199 Patient: yeah

200 Student: have you tried any of these

201 Patient: no i haven't (.) [no

Student: [no okay (.) so that might be something you want to think about

Patient: mmm

Student: cos you can apply them at home or just put it on when it’s feeling bad

Patient: yeah

Student: um (1.0) another thing that (.) people try is called um BANDING (.) i don’t know if you’ve heard of [that

Patient: [no

Student: where they apply >you could sort of think of it as a little elastic band around the haemorrhoid< to try and (.) um (.) get rid of the haemorrh[oid basically

Patient: [yeah (.) yeah

Student: and a lot of people do find that (.) really helpful=

Patient: =right

Student: and (.) you come in you don’t have to >sort of< stay overnight or anything in hospital you come in and it’s just a=

Patient: =a (.) a day procedure

Student: yeah (.) i mean it would involve (.) obviously the doctors inserting another (.) sigmoidoscope

Patient: [right

Student: [like you had before which can

Patient: it’s not pleasant [is it no

Student: [yeah (.) can be a bit uncomfortable (0.5) um (.) but as i said most people find that (.) quite (.) useful

Patient: yeah

Student: um sometimes (.) people get a recurrence of their haemorrhoids a bit later on

Patient: oh do they

Student: yeah (.) um (.) which is why (.) are you getting a bit uncomfor[table there

Patient: [it’sss alright i’ll just (.) change position

Student: is there something i can [(0.5) get for you

Patient: [no hhh. n-n-no it’s a ˚bit embarrassing but˚

Student: no yeah i can understand

Patient: ˚˚˚yeah˚˚˚

Student: have you tried one of those >sort of< ring cushions i’ve heard=

Patient: =well hhh. i have uh (.) because uh um my husband and i have a business at home >a book binding business<

Student: oh [right

Patient: [and obviously a lot of our work (0.5) is sitting

Student: mmm

Patient: and (.) it’s just been awful so i have (.) in recent times been (0.5) i sit on a circular cushion

Student: yeah

Patient: on my stool >and and< that has been able to (.) it’s just made it a little bit more comf[ortable actually cos it does help doing that

Student: [comfortable yeah yeah we should have one of them here [hhh.

Patient: [hhh.

Student: um (.) so (2.0) yeah i was just saying about the (.) binding (.) the=

Patient: =[banding

Student: [banding sorry yeah banding so that's another option (.) um that's=

Patient: =but there is a chance that they'd (.) would come back is there

Student: yeah um >sort of< (0.5) over the ne (.) over the following years some people do find that they come back (.) which is why it's probably useful to keep up with the [dietary things and=

Patient: [mmm =prevent it

Student: prevent (.) prevent it that way as well

Patient: yeah

Student: if they do come back we can (.) do it again (.) there are other procedures that we can do (.) but they tend to be reserved for once the haemorrhoids (0.5) um <u>get</u> a bit worse um because they're=

Patient: =what worse than ↑mine

Student: i-i know that sounds sound of >sort of< um

Patient: yeah

Student: but sometimes they can get to be a situation where they need to be removed under a like (.) a general [anaesthetic

Patient: [yeah (.) what would they do

Student: um (.) th-it's like a surgical procedure

Patient: oh right

Student: umm and the reason that we maybe conserve that til later is it's better for you (.) if we try all the easier options first (.)

cos we don’t want (.) you to have to have surgery

Patient: right

Student: does that make sense

Patient: hmm i mean (.) >yes it does make sense< (.) i-i-i’m not someone who likes hospitals very much[

Student: [no=

Patient: =but to be honest i have got to the point (.) now and i’ve been so worried about (.) so worried about this (.) um (.) i mean it’s great seeing the doctor at the hospital and it and it was good hearing him say it was p (0.5) it was ˚˚p-piles˚˚ (.) but i have been really worried about it

Student: what sort of things in particular have been (.) worrying you

Patient: well just that (.) well because there is ˚˚a bit of blood˚˚

Student: yeah

Patient: if i go to the toilet (0.5) and um on ˚˚on the paper˚˚ (.) and um (2.0) it’s just unfortunate really that my dad um (1.0) he had ˚bowel cancer˚ (.) and um (.)

Student: ˚˚˚sorry to hear [that˚˚˚

Patient: [i mean it’s (.) yeah (.) thank you (.) i mean it’s some years ago now but unfortunately we (.) he had an operation but we did lose him and he was only in his early sixties (.) and i think it just stays with you

Student: yeah

Patient: y’know a i (1.0) i just (.) i feel like i (.) i’ve really <u>suff</u>ered with this especially as my work is (.) is very s-

sedentary and i do spend a lot of time sitting still

Student: mmm

Patient: and i-i-i was just hoping i could have something done that would be per↑manent really

Student: well that’s very understandable um (1.0) the sort of (0.5) worry about

Patient: mmm

Student: other things (.) um (1.0) obviously the doctors at the hospital <u>are</u> very experienced and um (1.0) and um (1.0) you know you can be sure that they’ve done everything that they need to do (.) um (0.5) and as i said (.) we may find that one of these things (.) um like banding

Patient: mmm

Student: will actually clear up the problem for you really (.) >sort of< (0.5) easily with less pain and things um

Patient: yeah

Student: so for that reason it’s probably worth a try

Patient: mmm

Student: before going onto surgical procedures um (2.0) because we can always (.) move onto them (.) if the banding [doesn’t work

Patient: [mm (.) mm

Student: um (.) and obviously we want to do something (.) we want to get you out of pain as quickly as [we <u>can</u>

Patient: [yeah (.) yeah

Student: as well (.) um because it’s not ideal (.) at the moment (.) what are your thoughts

Patient: um

Student: which (1.0) or do you have any more questions about any of them

Patient: i mean the cream that you mentioned

Student: mmm

Patient: you said that that will help (0.5) it helps it make it easier to go to the toilet

Student: mmm

Patient: but (.) i mean does that do anything else is that all it

Student: um we can give you a cream that has a sort of local um (1.0) um a local (.) sort of pain reliever

Patient: oh that'd be great (.) [to start with

Student: [um (.) so to start (.) it m it may (.) it may work

Patient: yeah

Student: um just as a (.) a stop gap measure [until you decide what

Patient: [just to make it a bit easier

Student: yeah

Patient: but i definitely would like to have (.) some sort of treatment (.) whether it's (0.5)↑banding [thing

Student: [banding (.) banding yeah

Patient: maybe if you think that would be someth i-i-i'd really like to go for something at this point yeah i'm i'm (.) really fed up of having (0.5) having it all the time

Student: yeah (0.5) okay (.) well we're (.) running out of time (.) so we've spoken a bit

403 about (.) the (.) where the where your
404 haemorrhoids came from

405 Patient: yeah

406 Student: and what the treatment ( ) options (.)
407 might be for you

408 Patient: yeah

409 Student: you think that you'd quite like (.) the
410 cream (.) in the meantime and maybe to go
411 for the banding

412 Patient: definitely yeah

413 Student: if it's okay with you i'll (.) tell your
414 GP about

415 that [and he can arrange something=

416 Patient: [fine =yeah

417 Student: um sort of ASAP

418 Patient: lovely

419 Student: [so thank you for talking to me=

420 Patient: [thank you =you're
421 welcome

422 Student: have a nice day

423 Patient: thank you very much

Participant 008

Student: hello↑ (.) mr sa↑unders

Patient: that’s right (.) yeah

Student: >hi< my name’s hayley evenett and i’m a (.) fourth year medical student

Patient: right=

Student: =and i’ve been asked today to have a chat with you (.) is that o↑kay

Patient: yeah (.) of course yeah

Student: eh everything we talk about is confidential (0.5) uuu you sitting comfortab↑ly

Patient: well (0.5) yeah hhh. just about yeah

Student: would you like to tell me a little bit about why you’ve come in to see me today

Patient: umm (.) ye-yeah i’ve (.) come in to see doctor martin again after um (.) i’ve seen a consultant about um (0.5) what is apparently haemorrhoids y’know i’ve got problems with my (0.5) back passage so

Student: okay and how long’s this been going on for

Patient: um (1.0) it’s been particularly bad for the last six months (0.5) i’ve had it >it’s sort of< really (.) hff started to notice it about nine months ago and um (.) six months ago i just thought well there’s actually blood on the (.) toilet paper and ( )

Student: okay (.) and um you say it’s been particularly bad (.) what kind of symptoms are you getting

Patient: well i think that (.) um (2.0) obviously the blood on the on the er (.) toilet

paper’s not great but it’s just very very painful

Student: mmm

Patient: and um (.) i sit down a lot (.) at work y’know and um (0.5) after i’ve moved my bowels (.) sometimes things are protruding out of my back passage so (.) y’know (.) um

Student: must be quite uncomfortable [for you

Patient: [pff yeah (.) yeah

Student: and when you (.) when you first saw the blood was that something that was (.) worried you

Patient: well yeah it’s very alarming (.) yeah

Student: mmk and then did you come (.) and see the doctor

Patient: y-yeah i came to see doctor martin about six months ago and um (0.5) he referred me to a colorectal (0.5) c-clinic (.) and they

Student: okay

Patient: they gave me a sigmoidoscopy and er (.) dr martin that’s (.) °did his examinations°

Student: okay (.) um and so (.) today what are you expecting (.) from our (.) consultation

Patient: well i mean i’m really just hoping (0.5) that you know you can advise me on um (.) the best way forward >i mean i’m-i’m< getting so desperate now i really would go for quite drastic treatment

Student: °okay i understand° it must be (.) °a bit° difficult for you especially as you say you sit down a lot at work

Patient: well yeah i’m using a cushion to sit on now i mean y’know (.) um (.) it is my own business but there doesn’t seem to be a way round it really i-i do have to sit down a lot when i’m working

Student: what do you do↑

Patient: i-i’m a book binder and [printer

Student: [oh okay (.) uh interesting

Patient: yeah

Student: do you en↑joy it

Patient: oh very much yeah (.) yeah (.) and i can work from home and uh (0.5) y’know w- business is good at the moment so (.) yeah

Student: okay (.) so if i can just sort of (.) uh just so i KNOW myself what’s been going on (.) if i could just (.) say what you >sort of< told me and you can let me know if i get anything wrong (.) so (.) do you say it’s been going on (.) it’s been really bad for six months <˚now˚> but it had been (1.0) [eh

Patient: [it started to (.) be more sort of regular (.) this thing (.) y’know uh of (.) discomfort [sitting down

Student: [yeah

Patient: and and noticing things around my back passage after i’d moved my bowels and so on and then (.) when blood started to come i just thought this is (.) terrible i’ve got to (.) go to the doctor ↓now

Student: yeah and then (.) he um (0.5) did an examin↑ation >the GP< and then sent you to a clinic (.) where they did further examinations and investigations and they found out you’ve got haemorrhoids

Patient: yeah

Student: um and then you've come in today to (.) try and find out what options you have

[to try and get this treated

Patient: [yes (.) yeah

Student: is that correct

Patient: that's right (.) yeah

Student: and um (.) does this (.) is this something that you've experienced before ↑at all

Patient: well the thing is er (.) i've had (.) what i (.) realised about eight years ago is IBS

Student: right

Patient: um (.) had that for about twenty years

Student: °°oh gosh right°°

Patient: so it's no wonder i've got (.) diarrhoea and then suffer constipation y'know and er (1.0) i suppose that must relate to i mean can you tell me a bit about why [i might have

Student: [yeah is that (.) is that your idea about why you might have got haemorrhoids (.) [do you think it's to do with the IBS

Patient: [um (.) i think it must be associated with something to do with that (.) yeah

Student: mmmk (.) well would you like to tell you a little bit about (0.5) um well what do you already <u>know</u> about haemorrhoids sorry

Patient: um they're some sort of blood vessel (.) er they that's expanded

Student: okay (.) would you like me to go on and talk to you a little bit about what

haemorrhoids are [and (.) what may have ↑caused them

Patient: [yes (.) yes please yeah (3.0) yeah

Student: um and we can then discuss treatments

Patient: okay

Student: does that sound alright to you

Patient: yes (.) yeah

Student: you're you're correct in saying that they're vessels (.) um (.) so basically if this is your um >excuse my drawing< refers to your back passage for example (.) um basically haemorrhoids are one of those vessels and they get swollen because of the amount of blood they sort of pool (.) um (.) blood pools inside a vessel

Patient: alright

Student: okay (.) and that can protrude through (.) um the wall of your er back passage

Patient: alright

Student: um and sometimes (.) they will just be right inside and you ↑won't even know you've ↓got them

Patient: right

Student: but you said you're feeling some around (.) your back passage

Patient: yeah

Student: um so sometimes they can (.) shoot out (.) okay (.) and that's what causing you >sort of< your discomfort and you can feel them (.) um (0.5) and though (.) basically caused by an increase in pressure in your vessels (.) so you said you've got IBS (.) um and you said that sometimes you have constipation (.) so you're going to

obviously be um st↑raining when you're on the toilet and that can increase the pressure

Patient: right

Student: um (.) also (.) passing um hard (.) large ff-uh-stools can cause haemorrhoids

Patient: kay

Student: um (1.0) and the symptoms you're describing is what you do get with haemorrhoids (.) um so (.) blood (.) after passing and stools on the tissue and things like that (.) pain (.) discomfort (.) >and you may also feel like< you haven't quite emptied (.) your bowels (.) [do you ever feel that

Patient: [mm (.) yeah sometimes (.) yeah (.) i mean why is it so painful

Student: um (3.5) just because where (1.5) at the neck (0.5) of the haemorrhoids (.) they they're they're can get quite tight and they can um (1.0) where you're where you're trying to force out faeces (.) that can strangulate ↑them and that can um they can get things like (.) um clo-blood clots in them make them really really painful

Patient: gosh yeah

Student: um (.) and so (.) the other symptoms you can also get (.) like i said blood and painful but (.) discharge and things like that (.) can come (.) um from haemorrhoids

Patient: right yeah i mean the consultant said that they were a grade two (.) um (.) i don't know how bad that is [but um

Student: [okay (.) um (.) well grade two is (1.5) this is grade one so you very tiny can't see it (.) grade two is still inside your back passage

Patient: right

Student: um and grade three are ones that (.) um protrude out

Patient: right

Student: you can also get ones which are (.) not coming from inside but (.) look a little bit like skin tags

Patient: =right

Student: =just around (.) um your anus

Patient: really

Student: okay so they’re the different kinds of grades

Patient: okay

Student: does that (0.5) make

Patient: >yeah yeah so it< so it goes up to (.) how-what’s the worst grade th[en

Student: [four

Patient: four okay then so i’m about (.) >sort of< obviously about halfway to (.) i mean what about treatment then can you give me any advice about that

Student: yeah (.) um (.) do y-have you heard about any treatments

Patient: um i think i knew somebody that had (.) bands put on and

Student: yeah (.) okay that’s (.) that’s one of the treatments that’s um available (.) basically what they do is they’ll have a look up and um they’ll insert (.) like a little tube (.) and it’s got a little elastic band (.) and they’ll find where the haemorrhoid is (.) and they’ll just place (.) they’ll (.) sounds like it’s quite f( ) elastic band around the neck of the haemorrhoid (.) what that

244 does (.) is cut off the blood supply and
245 eventually then (.) the haemorrhoid will
246 just fall out

247 Patient: right

248 Student: that’s one of the options

249 Patient: yeah

250 Student: the other option you can have them
251 injected (1.0) and that causes them to
252 shrink

253 Patient: right

254 Student: um and then also um (.) you can have them
255 frozen off

256 Patient: right

257 Student: or if none of the above options work (.)
258 then you can have surgery (.) to remove
259 them

260 Patient: okay

261 Student: but there are other er (.) things that
262 don’t involve this kind of thing to help
263 you

264 Patient: right

265 Student: with your um haemorrhoids and to

266 Patient: okay

267 Student: prevent other things so like (.) um make
268 sure you eat lots of fibre

269 Patient: [yeah

270 Student: [>do you< (.) i know you have IBS so it’s
271 quite ↓difficult

272 Patient: well uh um (.) the doctor sort of er (.)
273 prescribed me some fibre gel and so (.)
274 that seems to help i buy some generic form
275 of that

276 Student: mmm

Patient: you know (.) um from holland and barrett (.) and er (0.5) it seems m-maybe i should take it more now i suppose

Student: yeah fibre helps you to move your stools a lot easier

Patient: mmm

Student: makes it go more frequent

Patient: yeah mm

Student: and that should help (.) also drinking plenty of <water>

Patient: yeah

Student: um and (.) going to the toilet whenever you need to go >so not< leaving it for stools to get too hard

Patient: right

Student: um and those are the kind of things you can help to try and prevent (0.5) um haemorrhoids (.) coming

Patient: okay

Student: appearing (.) does that (1.0) do any of those options the treatment options that i said do they (.) cos you seem [quite desperate ( )

Patient: [well i'm- i'm keen to get them sorted out (.) ummm suppose i'm almost thinking what would be the least painful (.) treatment to have (.) but you know um (.) perhaps if i was to (0.5) to take the fibre gel again (.) sort of thing (.) that would help

Student: i mean you sound like you're in quite a lot of pain um (0.5) so (.) maybe go um (.) one of these options to get rid of the ones you've already got (.) um as well as using the other (.) >sort of< conservative

(.) methods and drinking lots of water and the fibre gel

Patient: right

Student: i think banding seems to be quite (.) popular

Patient: does it

Student: um (.) but what (.) what sounds

Patient: i don’t (.) i-i can’t really tell because i suppose >you know< (.) th-they all sound a bit painful if (.) um i mean uh you kind of think maybe the injection would just actually make them (.) go away if that wasn’t painful maybe that would be the least uh

Student: i think (.) i don’t think banding or the injections are actually ↓painful (0.5) um you shouldn’t be able to feel that at all

Patient: really

Student: no

Patient: okay

Student: if that’s worrying you (.) i mean i can give you some leaflets which can (.) you know give you some more information about the different types of treatment options and you can maybe go away and have a think about that and talk more to doctor martin

Patient: okay

Student: about that

Patient: yeah

Student: does that

Patient: yeah okay (.) i’ll have a

Student: you’re happy with that

Patient: yes thank you (.) yeah

Student: are there any other questions (.) that you

Patient: umm

Student: have that i've (.) missed out

Patient: i can't (.) i mean sss (1.5) obviously when you see blood in your stools it's (1.0) it's quite concerning about [what that might be

Student: [yeah of course (1.0) yeah

Patient: you think that might be anything else °at all°

Student: er-you said it's fresh ↑blood (.) didn't you (.) and it's very red

Patient: yeah=

Student: =on the tissue (.) that and they've looked inside already (.) um and they've found <u>haem</u>orrhoids (.) which again (.) and they've (.) y'know (.) diagnosed that so it's very unlikely that you'd have <u>any</u> other (.) problem cos it's fresh blood (.) but they'll give you advice on (0.5) um if you're still getting symptoms to come back and have more investigations

Patient: yeah

Student: but by the sounds of it (.) through what they've done already for you

Patient: yeah

Student: they diagnosed (.) haemorrhoids is the very [definitely ( )

Patient: [okay (.) it's just that you know obviously other things (.) y'know your mind kind of wanders to (.) what it could be [and could be quite serious couldn't it

Student: [yeah of course (.) must be worrying for you

380 _____

381 |

382 (ø) (3.0)

383 |

384 Patient: _____ tt

385 Student: okay (.) thank you so much for coming to
386 talk to me today

387 Patient: thank you

Participant 009

Student: hello my ↑name’s rob (.) i’m a fourth ↑year ↓medical student (.) thank you for coming to see me today

Patient: s’alright

Student: um (0.5) i understand that you want to speak to your GP °°jss°° are you happy to talk to me

Patient: yes UM (.) my niece is a medical student she says it’s really useful to (.) er (.) talk to patients now

Student: thank you very much (.) the er (.) the same privacy rules apply (.) even though i’m not a doctor (.) although i will be discussing °your case° with the GP (0.5) if that’s okay with ↑you

Patient: yeah that’s fine (.) yeah

Student: so i’d like to start by (.) asking a few questions and i’d like to find out what brought you here (.) so (.) how old are you please

Patient: i’m fourty two

Student: fourty two (.) and >what do you ↑do<

Patient: um actually got my own business er (.) business book binding and printing

Student: o[kay

Patient: [°display° at the (.) bottom of the garden really and=

Student: =that’s ↑really interesting

Patient: ↑yeah it’s it’s a nice er (.) nice (.) place to work y’know (.) nice way to work

Student: ˚˚kay˚˚ fantastic (.) so (.) what brought you in to see your GP today

Patient: umm i've actually had (.) quite a problem with um (0.5) um IBS for (.) for (.) >sort of< twenty years or so (.) and um (.) i think perhaps that's led to (0.5) um (0.5) piles that i've got

Student: kay

Patient: and i came to see doctor martin about (.) six months ago it was (.) it was getting very very (.) p-painful and (.) and difficult (.) and um he send me to a (.) colorectal clinic and i saw a (.) saw a specialist

Student: sure (.) and how did that go

Patient: um (.) they said i've got grade two (.) haemorrhoids (1.0) um (.) er (.) really i (.) must get something done about that (.) y'know i don't know what ˚to do˚ (1.0) i just can't go on like this really

Student: it must be really >affecting you< as well

Patient: i-it does you know i have to sit down a lot [um for my work

Student: [mmm

Patient: as well (.) whatssit just seems what i always have to do that y'know (.) i always sit on a (0.5) >sort of< circular cushion and ˚yes it's˚ (.) so painful and er

Student: it's pretty rotten isn't it

Patient: yeah yeah (.) it seems a bit (0.5) er unfair

Student: so you say that it's affecting you when you're sitting down (.) is it affecting you in any other ways at ↑all

Patient: well there's always like eh-eh (.) blood on the toilet paper and um (.) sometimes

it actually seems like they come out (.) from uh (0.5) back passage when i (.) just (.) y'know move my bowels and so on

Student: a lot of people carry around spare (0.5) underwear and things like that (.) is it that bad for you yourself

Patient: uh no no (.) but i'll (0.5) think about it hhh.

Student: hhh. yeah (.) i'm sure you did

Patient: yeah

Student: so (.) what i'm gona do is just feedback on your topic (.) and just make sure i've got the right idea

Patient: mkay

Student: so (.) you recently (0.5) um (.) realised that you'd got piles (.) and you've gone through investigations which involved (0.5) a camera up the back passage

Patient: that's right (.) yeah

Student: °°things like that°° (0.5) and they told you you'd got grade two haemorrhoids

Patient: yeah

Student: are you aware of what that means

Patient: not really no

Student: okay (0.5) well (1.0) i think what i'd like to do (.) is talk a little bit about what haemorrhoids are (0.5) if that's okay with ↑you

Patient: okay

Student: and then we'll talk (.) about some of the treatments that are a[vailable

Patient: [ther-that'd be great yeah

Student: is there anything else that you'd like to (.) talk about

Patient: um (.) well i (.) i suppose i (.) it's quite worrying when you see blood coming out your back passage

Student: sure (.) do you

Patient: you don't think it's anything worse do you

Student: °okay° (.) well (.) what i'd like to do (.) is (.) um (.) talk about haemorrhoids first (.) talk about treatments (.) then talk about your (.) other worries that you have (.) if-if that's o↑kay

Patient: okay

Student: okay so (.) haemorrhoids are basically (.) uh we call them a vascular pad (.) and that's just a very posh word for just a protrusion (.) that [is inside your back passage

Patient: [right (.) yeah

Student: and (0.5) like you said before there's four types there's grades one to four (.) grade one is when it stays (.) within the back passage (0.5) grade two is when it comes out when you're straining (.) when you go to the toilet etcetera

Patient: right

Student: grade three is when it comes out completely (.) but it all goes back in afterwards

Patient: ri[ght

Student: [grade four (.) is when it stays out (.) all the time

Patient: right okay [then

Student: [so that's (.) kind of four levels of severity

Patient: yeah

Student: and you’re a grade two

Patient: >okay< does that mean i’m going to get worse then

Student: ummm it has the potential to get worse but hopefully with the treatments we’ll talk about later [that won’t necessarily happen

Patient: [okay (.) yeah

Student: okay (0.5) so (.) it’s quite a common thing >it happens to a lot of people< (.) and um it’s associated with a number of factors

Patient: do you think it’s my IBS that’s (0.5) causing some of the problems

Student: i-i-it could be (.) i m[ean

Patient: [cos that’s what i thought

Student: yeah (.) uh-u i mean (.) are you often constipated

Patient: s-sometimes constipated (.) sometimes diarrhoea and shh

Student: um cos it’s quite variable isn’t it >would you say that you’re< predominantly kind of (0.5) constipated

Patient: yeah probably (.) yeah

Student: so that could be (.) one of the reasons

Patient: °°okay°°

Student: °why you developed this problem° (0.5) so (.) um (.) it’s a relatively common problem that happens to a lot of people (.) and obviously we don’t (.) often like to talk about things like that [and so

Patient: [mmm

Student: that's why you perhaps feel a little bit (0.5) embarrassed (.) and (.) uncomfortable about it

Patient: yeah (.) i do yeah

Student: um (1.0) have you got any other questions about haemorrhoids specifically or shall i move on to the treatment

Patient: so (.) d-you think i've got it (.) basically from (.) having constipation and

Student: that seems most likely (.) to me

Patient: °>alright<° and that would give it to you because it's (.) too hard to push the

Student: yeah

Patient: °stuff out°

Student: one of the treatments actually (.) is (.) um (.) basically softening the stool (.) to make sure that you don't kind of (.) er worsen it by having quite (.) hard (.) stools (.) cos obviously that (.) because it's a pressure problem (.) that will make it worse

Patient: >°ah right° i was< (.) doctor martin actually gave me umm (.) the GP gave me (.) um (.) fibre gel

Student: mhmm

Patient: to take (.) perhaps i should take some of that yeah

Student: did you (.) not feel that helps

Patient: i-i've i've took it for a while i mean it's just all a bit unpredictable (.) >i think it did enough actually<

Student: mmm

Patient: it did help

Student: tch (.) there's basically (.) um three kind of stages of treatment (0.5) so the first one is conservative measures (0.5) so that's things like (.) make sure you've got (.) fluid in your diet (0.5) have a high fibre diet (0.5) um (.) try stool softeners like that you suggested >fibre gel< (.) um (.) and (0.5) so it sounds to me like you've tried some of those things already and it just hasn't really=

Patient: =well it jus (.) i-i've tried the um (.) fibre gel for a bit >that was (.) that was< really before this (.) whole thing (0.5) came on n yeah (.) i um (0.5) yeah (0.5) perhaps i should try it again

Student: kay

Patient: yeah

Student: um (.) well there's nothing to stop you continuing that whilst you try other things at the s[ame time

Patient: [no

Student: so i would recommend you do that [°°if you find that does help°°

Patient: [okay

Student: the second stage is (.) various ointments and creams (.) which you can (.) talk to your pharmacist about

Patient: right

Student: and (0.5) you said earlier that you're getting a bit of pain (.) from these (.) um

Patient: yeah >i suppose< bit itchy sometimes (.) as well

Student: hmm (.) you can actually buy (.) um (.) kind of pain killing creams over the counter

Patient: [yeah

Student: [from your pharmacist and so (0.5) have you tried anything like <that> before

Patient: no (.) no (.) it is very painful n ( ) would be (.) doing that (.) yeah

Student: th-that might be worth trying but the trouble is you can’t use it for too long because you can (.) end up sensitising your skin in the long term (.) so that’s kind of=

Patient: =oh really

Student: if you get a flare up (.) you might find those creams help

Patient: okay

Student: but something you can’t take long term

Patient: right

Student: n finally the last stage of treatment (.) is (.) will involve an outpatient procedure at the hospital (0.5) where we can either tie a band around the haemorrhoids (.) and (.) make it drop off (.) or (.) you can inject (0.5) an agent ( )which would cause it to sclorose (.) so that means to kind of shrivel

Patient: right

Student: and go away (.) how do you feel about (.) um (.) those options

Patient: um (.) well i am (0.5) i mean putting a band around it sounds quite painful but it’s

Student: mmm

Patient: uuummm (.) but i am (.) y’know just wana get (.) rid of them right now i could just get rid of them and move on that would be fantastic

Student: it sounds to me like you just want to (.) put all this behind you

Patient: oh definitely (.) kind of a phrase

Student: yeah so (0.5) i think (.) from what you've told me to sounds like we should move onto the third stage of the treatment which would be the outpatient procedure

Patient: right

Student: and um (.) what i'd like to do is to talk to the GP about what °°( )°° if it's okay with you (.) um (.) i talked earlier about (.) um (.) banding procedures and injecting sclorosing agents

Patient: mm

Student: i mean have you heard anything about that before (.) or

Patient: i think i (.) yeah i think i heard about somebody having injections

Student: mhmm

Patient: i don't know that sounds a bit less painful than having a band put round but i suppose you have to be (0.5) guided by the

Student: by the specialis[ts yeah

Patient: [doing it

Student: i think that's (.) that-d ju- a special decision to make really (.) that's not really something that i can (.) comment on

Patient: yeah

Student: but i would recommend you go and speak to the (.) >°°consultant°°<

Patient: yeah

Student: and um (.) have a look (.) see what

Patient: mkay

Student: how does that sound to you

Patient: yeah (.) i mean you don’t think i-it’s a sign of anything worse >i mean obviously when you see blood coming out of your back passage< it’s quite worrying

Student: mm (.) w-well why d’you think it would be worrying

_____

|

(2.5)

|

Patient: _____ well i (.) my dad had um (.) sort of (.) bleeding from his back passage and it turned out to be bowel cancer

Student: mm

Patient: yeah (.) h-he had er (0.5) y’know er (1.0) his colon taken out

Student: mmm

Patient: but um (.) still died anyway

Student: really

Patient: yeah

Student: how old was he °when he was°

Patient: he was sixty

Student: sixty (.) okay (3.0) um (.) °given that you’ve had the camera up the back passage (.) i think it’s relatively unlikely (.) to be (.) uh (.) a malignancy of that sort°

Patient: right

Student: but if you’d prefer (1.0) um (.) i can talk to your GP about it

Patient: mmk

Student: and he can talk to you (.) when we've got more time

Patient: alright

Student: or would you RATHER we talked about it now >it's completely up to you<

Patient: um (.) well if you think that it's been (0.5) if you think that he's had a look with the camera [then i suppose

Student: [mmm

Patient: that's (.) that should be (.) alright >shouldn't it< he would have looked >wouldn't he< for

Student: yeah (.) i-i would say it's relatively unlikely (.) um (.) usually with um malignancies you get blood that's mixed in with the stool

Patient: right

Student: whereas with (0.5) what you've described to me it'd usually be coating the surface (.) it's just (.) i mean (.) h-how how is it for you

Patient: uuum (0.5) well it's just on the toilet paper=

Student: =just on the toilet pa[per

Patient: [sss quite bright (.) red yeah

Student: °°probably° (.) it does sounds relatively unlikely (.) although if you're worried we can (.) certainly arrange further investigations to

Patient: okay

Student: (so kind of) stop you from (worrying about it)

Patient: okay (.) right

Student: so (.) i'd like to draw this to a close (.) but before we do (.) we've got time for questions if you have any (.) um

Patient: um (.) i can't think of any (.) anymore really i mean obviously (1.0) th (.) there are more extreme things they can do but (.) mine aren't really that bad are they in terms of some people's i suppose if they go back in again

Student: well (.) the thing is (.) we're meant to be the experts here in (.) the actual disease but you're the expert in who you are (0.5) as a person (.) so really the scale of one to four isn't really that important (.) if it's causing you a problem

Patient: yea[h

Student: [then it's a problem

Patient: yeah

Student: um s so i would like to do something about it

Patient: okay

Student: so what i'd like to do (.) is um (.) i'll talk to your GP about this (.) and you'll probably get a letter through the post

Patient: right

Student: in probably the next (.) six to eight weeks

Patient: mmm

Student: offering you an appointment to come in and talk to the specialist

Patient: okay

Student: in the meantime (.) if you have any questions (.) i can refer you to (.) a

website which is (.) >patient.co.uk< (.) type in haemorrhoids

Patient: right

Student: it’ll come up with loads of really good stuff

Patient: right

Student: and also you’ve got (.) the practice phone number (.) you can always give me a ring (.) or come in and have a chat with me

Patient: okay (.) thank you

Student: is there anything else i can do for you today

Patient: uh (.) no i don’t think so (.) thanks very much

Student: thanks for your time

Participant 010

Student: um hello mr saunders↑

Patient: that’s right (.) yes

Student: hello my name’s jen musto (.) i’m a fourth year medical student at u e ↑a (.) and um (.) i’ve spoken to your GP and (0.5) he suggested that i come and talk to you about some of the >problems that you’ve been having<

Patient: oh yeah that’s okay yeah

Student: okay (.) well um before we begin are you comfortable

Patient: yeah not too bad thank you

Student: okay (.) um so everything we discuss will be confidential between ourselves and the GP (0.5) °okay° (.) um so first of all it’d be good for me if i could just get a few baseline questions out of the way (.) um like your occu↑pation

Patient: um (.) i’m actually uh a bookbinder

Student: oh (.) okay (.) and um (.) your age

Patient: i’m fourty two

Student: your fourty two (0.5) okay (.) thank you very much (.) and now if you could just begin by telling me a bit about what’s been happening to you

Patient: oh okay well (.) umm (1.0) i (.) i went to the doctor (.) six months ago (.) cos uh (.) i was getting sort of a lot of (.) pain in my (0.5) back °passage° (.) discomfort and so on (.) um (0.5) and i’ve had some sort of inkling about it for quite a long time >and i think i’ve got IBS< (.) y’know had that for a while as

well (0.5) um he had a look (.) and um (0.5) since then had a sig-moidoscopy (0.5) uuum (.) and (.) i was told that i've got grade two haemorrhoids (0.5) um (.) i really want to get this sorted out now i mean it's just s-so painful and inconvenient and uh (.) i don't get a lot of sympathy really at home so (.) um if there's some some way to just clear them up once and for all that'd be great

Student: okay (.) so do you know much about haemorrhoids

Patient: um (.) something to do with blood vessels isn't it (.) um

Student: yeah

Patient: yeah

Student: yeah that's (.) that's correct (.) um would you like to know a bit about what haemorrhoids=

Patient: =yeah i think it would be useful yeah

Student: okay (.) well you're right it is to do with blood vessels and it's where they um (.) are sort of slightly larger than perhaps they should be and sort here's an (.) example uh (.) illustration i don't know if this is helpful

Patient: right

Student: and uh (.) here shows the different (.) uh sizes and you mentioned that yours is a grade two

Patient: yeah

Student: so that would be (0.5) this type here

Patient: ri[ght

Student: [and as you can see it doesn't come <u>out</u> (.) of the uh anal canal (.) it stays

within (.) but it can give you (.) the symptoms that you (.) told me about

Patient: right (.) sometimes they do feel they're sort of (.) um protruding a bit but they go (.) back

Student: yes (.) yeah (.) and that's once you've passed a bowel movement

Patient: yeah (.) yea[h

Student: [right (.) okay (0.5) and so is there anything else that you (.) want to know about

Patient: well i mean i'm (.) i am quite concerned that it's um (.) not a sign of anything else (.) it (1.0) um (1.0) i mean the (0.5) the er consultant didn't really say an awful lot to me he was a bit sort of (.) y'know (.) quiet or something

Student: ri[ght (.) okay

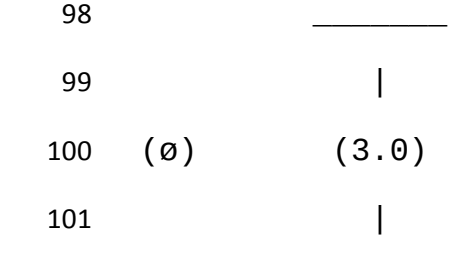
Patient: [um (.) d'you (.) can you (.) i mean (.) do you >know if it's< anything i need to worry about or

Student: is there something that you have in mind

Patient: well my (.) um my dad had bleeding from his back passage and uh (.) it turned out he had bowel cancer

Student: right (1.0) okay (0.5) and is y'know is this something that concerns you

Patient: well you know obviously yeah (.) it didn't work out very well for him (.) i mean



Student: _____ okay well i'm sorry to hear that (.) and um i (.) i think it's right that you are concerned because um in your father's case (.) um when there is bleeding in the back passage that can (.) um indicate that there's something serious going on

Patient: mm

Student: but it's important to remember that there's many <u>other</u> causes (.) for bleeding (.) um some as in-in your case haemorrhoids which is a very (.) uh benign condition (.) meaning that >y'know< it really is=

Patient: =doesn't feel that way °°but y'know°°

Student: um (.) i-i understand this must be difficult for you

Patient: yeah

Student: um (.) >but yeah< (.) i want you to be reassured that (0.5) they've found out what your problem is and (.) it is treatable

Patient: do you think they'd have looked to see if it was (.) cancer or not (.) or

Student: well with the sigmoidoscopy they would have been able (.) to check your um (1.0) the lower part of your colon

Patient: right

Student: and um (.) obviously that doesn't (0.5) exclude (0.5) everywhere

Patient: hmm-[no

Student: [near your bowel

Patient: so there's quite often blood on the (.) toilet paper and stuff

Student: right okay (.) and can you describe what the blood was like

Patient: it was red

Student: ˚˚it was red (.) okay˚˚ well um (.) often they say that when the blood is more fresh er red-dy colour (.) that's likely to be something from around the area (.) like haemorrhoids (.) or perhaps (.) if the blood was darker (.) or mixed in with the stool itself (.) that would indicate a bleeding higher ↑up

Patient: right okay

Student: so that would be something you could look for

Patient: okay

Student: um and then (.) you would (.) want to see your doctor about that (.) and if you were feeling unwell (.) if you (.) er lost weight (.) if your um bowel habits changed (0.5) that would be something (.) to (.) see your doctor about

Patient: right

Student: so has any of ↑that happened you

Patient: um (.) in terms of

Student: weight loss:: or

Patient: no (.) not really i've always been fairly ( )

Student: okay

Patient: um

Student: well i think that-that's reassuring then

Patient: yeah (.) yeah i mean i (.) y'know (.) obviously i have got (.) haemorrhoids so it's probably that

Student: yeah

Patient: um (.) what kind of treatments are there that i can kind of have (.) i mean is there any way i can just clear it up once and for all

Student: um yeah (.) there are lots of treatments ranging from what we call conservative so (.) just sort of doing very basic (0.5) lifestyle changes (.) through to er surgical (.) options (.) so um a more definitive treatment would be the more surgical procedures so do you want me to go straight to ↑them or would you like me to=

Patient: =could you just tell me what there is

[i mean i

Student: [yeah

Patient: on the one hand i want to (.) get rid of them >but i don't< you know i don't want to have surgery really

Student: okay

Patient: ( ) that

Student: of course (.) right (.) so conservative things would be (.) just helping (.) preventing getting them in the future (.) and easing some of symptoms that you are experiencing (.) so it's important to drink lots of ↑fluid (0.5) um try and have a high fibre diet so fruit veg bran things like that

Patient: thing is though obviously the (.) bran (.) i mean that (.) doesn't go with the IBS very well so

Student: right okay (.) well

Patient: gota be careful with some fruit as well (.) but okay i'll

Student: so fluids perhaps might be

Patient: yeah

Student: something that you could (0.5) try (0.5) also regular exercise (.) that can help

Patient: i do um (.) go for a walk (.) now and again y'know (.) i quite like to get out

Student: okay (.) well that's good (.) that's positive (.) um and then you can move on to (.) um things such as um injections (.) into the haemorrhoid itself

Patient: right

Student: ummm or you can use um like (.) a rubber b↑and (.) and that can be put (.) around the haemorrhoid (.) these will help the (.) sort of the blood supply diminish and eventually they'll drop ↑off (.) so that's another option (.) and there's surgical removal (.) as well

Patient: okay

Student: so there's a few (.) options there (.) does any of them >sort of< °°sound appealing°°

Patient: no hhh. not really

Student: hhh. sorry

Patient: well (1.0) i suppose the injection sounds like the least (.) radical really beyond just trying to not get them in the first place

_____

|

(ø) (2.0)

|

Student: _____ yeah

Patient: umm is that very painful or

Student: they give you a local anaesthetic

Patient: oh right

Student: maybe it’s a bit uncomfortable but it shouldn’t be painful

Patient: right (1.0) and that’d be suitable for the level of haemorrhoids i’ve got would it=

Student: =yes

Patient: okay

_____

|

(ø) (1.0)

|

Student: _____ s’something perhaps you could talk to your doctor about

Patient: okay

Student: okay so we’ve kind of covered what haemorrhoids are (.) treatments (1.0) available to you (.) um like (0.5) maybe the sounds of the injection

Patient: maybe yeah

Student: so is there anything else (.) um (.) going on at the moment that you want

Patient: um (.) no not really um (2.0) nah i think i (.) if i could sort this out cos i (.) i have to sit down at (.) with my job y’know

Student: right

Patient: as i say my (0.5) partner’s getting little fed up of me moaning about it so

Student: yeah

Patient: um

Student: cos you mentioned that earlier

Patient: well i think she thinks that i'm a bit too much sort of (.) making too much fuss really but (2.0) yeah she doesn't know what it's like y'know

Student: so has that been affecting you

Patient: yeah it's very (.) y'know very painful and (.) embarrassing (.) and y'know can't actually relax too much (.) go to the theatre of something like that (2.5) i mean (.) maybe the injections would sort it out n then it'll be sorted out

Student: yeah (.) i mean it's important that to remember that there is a treatment (.) and y'know there's different options available (.) so (.) i think (0.5) you should (.) not try and (.) not feel so (.) sort of as you are because there really are things that can make it better for you [and that's definitely a positive outcome

Patient: [okay (.) ah right (.) well thank you

Student: °°so yeah try not to worry too much°° (.) and i understand that your father is a concern for you as well (.) is there anything else in your family history

Patient: um no not really (.) no

Student: good (.) umm so just to complete my history i'm going to ask you a few more uh general questions (.) so we've touched on the fact you've got IBS (.) do you have any other medical (.) problems

Patient: not really (.) no nothing i can think of

Student: okay (.) alright (.) okay (.) and um (.) social history you live with your partner

Patient: yup

Student: um do you have any children

Patient: yeah we’ve got a daughter (.) she’s fifteen

Student: okay (.) and is she (.) a teenager or hhh.

Patient: she is yeah (.) fifteen yeah

Student: okay (0.5) brilliant (.) and (.) um you mentioned your job (.) is that going okay

Patient: yeah (.) oh yeah we’ve still got the contracts n yeah so it’s going well (.) sort of

Student: good (.) and are you on any medication

Patient: no

Student: okay (.) alright well uh thank you very much for talking to me today and i wish you the best of luck

Participant 011

Student: hello there my name’s (.) natalie sylvian i’m a fourth year medical student (.) um (0.5) the doctor’s asked me to come and have a quick chat with you today (.) before you see him (.) would that be okay with you↑

Patient: yeah that’s fine

Student: thank you (.) um can i just check your name↑

Patient: janice (.) janice saunders

Student: °okay° and do you mind if i ask how old you are

Patient: fourty two

Student: okay (0.5) um (.) well (.) thanks for agreeing to have a talk with me today (.) um (.) what i hope of this is >if it’s okay with you is< if we just sort of have a chat about what’s been happening

Patient: mhmm

Student: um (.) then hopefully i can (0.5) give you some information about what treatment options we’ve got available (.) and (.) then we can sort of come to a decision

Patient: yeah

Student: ↑between the two of us

Patient: yeah [that’s

Student: [↑↑if that’s o[kay

Patient: [yeah that’s lovely thank you

Student: and everything we talk about is confidential=

Patient: =okay

Student: so um (1.0) please feel free to be open

Patient: okay

Student: um (.) so (0.5) what brings you to see the doctor today

Patient: um (.) well i'm ↑hoping that we're gona (.) talk about (1.0) what we can do about (.) the problem that (.) ↓i have

Student: °okay°

Patient: um (.) i went to the hospital (1.0) saw a specialist (.) and um (1.0) um (.) just sort of hoping that we can go through what's next (.) y'know what we can do next (.) rea[lly

Student: [okay (.) okay (.) ummm do you think you could just (.) briefly outline about (.) what the main problem is (.) for me

Patient: um (.) well (.) about (.) >six months ago< i noticed (0.5) um (.) uh-uh when i went to the toilet that there there was °there was some blood there°

Student: okay

Patient: umm so (.) i came to the (.) my GP

Student: yep

Patient: and um (.) he said that he thought it was probably (0.5) um (.) haemorrhoids

Student: okay

Patient: but he thought that i should see °someone° (.) so i went to the hospital (.) and they did um (1.0) one of those um (.) is it the (.) sigmoid (1.0) err (.) the sigmoid[oscopy things↑

Student: [yep

Patient: and um (.) and then they (.) the specialist said afterwards that (.) um he thought it was

Student: okay

Patient: umm (.) and that's it ↑real↓ly (0.5) but (.) you know that was six-six months ago was when i originally came to see my GP

Student: right

Patient: um (1.0) and since then they've (.) got worse [i think (.) yeah

Student: [okay (.) ˚okay˚ (.) um well that's brilliant i (.) seem to feel like i've got a good idea about what's happening (.) can you just tell me a bit about (.) how they're >sort of< affecting you day to day

Patient: um (0.5) well they're really (.) exc↑ruciating (.) sometimes (.) i-it you know in the in the espesh (.) in the last six months they've got worse (0.5) but in the last few weeks they (.) i think they've really got (.) much worse and um (.) i'm self-employed my husband and i've got um (.) book binding company

Student: ˚˚yeah˚˚

Patient: um so we work from home

Student: okay

Patient: but it does mean that i (.) sit (.) a lot

Student: yeah (.) that's [the thing

Patient: [and it's JUST awful so (.) wha-what i've been doing is (.) um (.) i've got this little circular

cushion[

Student: [right

Patient: that i've sort of been sitting on (.) and that seems to help

Student: mkay

Patient: i-it (.) it sort of just makes my day a bit easier

Student: okay

Patient: but by no means (.) comfortable [really

Student: [alright (.) okay (.) that must be (.) really (.) frustrating for you=

Patient: =well it is because you can't (1.0) you can't really concentrate on what you're doing at work because really all you're ever thinking about is [the pain that you're in

Student: [no

Patient: you know

Student: i can understand why you'd really want to (.) get it >sort of< sorted=

Patient: =i really do yeah

Student: yeah (.) well hopefully we can um (.) we can (.) help you ( )

Patient: i hope so yeah

Student: yeah (.) um okay (.) so (0.5) um (.) if it's okay now with you (.) if i (.) sort of give you a bit information about (.) um the options available

Patient: yeah

Student: um (.) would you like to know >do you know about haemorrhoids themselves< <or>

Patient: I DON'T REALLY N- (.) well i know how they feel hhh. (.) but i don't really know (.) what they are

Student: right (.) okay (.) so if i (.) explain to you sort of what they are and why they're (.) what causes them

Patient: ye[s please

Student: [and then um (.) what treatment (.) options >as there are lots of them<

Patient: yea

Student: we've got

Patient: [oooh lovely (.) yeah

Student: [and then sort of pros and cons of each↑

Patient: y-yeah please

Student: okay

Patient: yeah

Student: um (.) okay so (.) um haemorrhoids what they are is um (1.0) around (.) around the back passage (.) um there's lot of (.) um (.) veins now do you know what veins are

Patient: yeah yeah

Student: okay (.) so um (.) they sort of become (.) um >sort of< bigger than they should be

Patient: mhmm

Student: and (.) um (.) that's really what a haemorrhoid is

Patient: oh really

Student: it's just a vein with lots of blood in it

Patient: oh really

Student: and um (.) i know that they're very painful

Patient: mmm

Student: um (.) but (.) um (.) sometimes they can (.) be inside (.) or sometimes when (.)

they get worse they can actually come outside=

Patient: =that’s what has happened [with me

Student: [is that what (.) okay

Patient: yeah

Student: okay

Patient: yeah

Student: so um obviously then (.) if you’re sitting on them then that’s going to be really painful

Patient: mm

Student: okay (.) so um (0.5) they’re very common (.) um half of the population huv have them at some point in their life [so

Patient: [nobody ever talks about [them though do they

Student: [no they don’t but

Patient: i don’t know anyone (.) well £i-i-i probably do↑ but i no one hhh.£ (.) ever talks about them

Student: £hhh. yeah (.) so don’t be embarrassed at all about them (.) um (.) they’re very common and um (.) they’re caused by >so you’ve got these these< veins

Patient: mmm=

Student: =and if you’re sort of (.) straining when you you go to (.) to the toilet

Patient: mm

Student: that’s going to sort of (.) um (0.5) it makes lots of blood go into that area (.) and that’s what’s making them >sort of<

Patient: oh

Student: really big and painful

Patient: oh

Student: and then (.) every time you sort of (0.5) um (.) if you if you're passing like a <hard> stool (.) then that's obviously going to make it worse as well

Patient: yeah

Student: i mean (.) i don't know (.) what (.) things are like for you

Patient: they're not good really i've (.) i've had IBS for (0.5) years

Student: right

Patient: i mean probably twenty years

Student: okay

Patient: um (.) i didn't know it was that until (0.5) i would say about (.) seven or eight years ago >when there was a lot in the news about it< and that n that's when i thought oh (0.5) this (.) because ss- sometimes i'm (.) really °i'm constipated°

Student: yeah

Patient: and then other times (1.0) i seem to get (.) like uh it's almost °like diarrhoea°

Student: yeah

Patient: um and um and i do get like tummy cramps and things

Student: yeah

Patient: so i think probably (.) from what you're (.) describing (.) that's probably wh- (.) um what's happened i would [imagine

Student: [yeah (.) yeah (.) do you notice if they're worse when you've got (.) more constipation than

Patient: i don’t know if they’re worse or better to b- (.) i think both sort of seems to >sort of< bring them on

Student: okay

Patient: for some reason

Student: yeah (.) definitely sounds like something you need to look i[nto

Patient: [mmm

Student: okay so (.) um (.) have i explained (.) well enough to you [what they are

Patient: [yup yup (.) yeah ( ) °sounds horrible doesn’t it° hhh.

Student: hhh. £don’t worry they’re they’re (.) as i say£ they’re so common (.) sort of half of the people will have them at some point (.) so

Patient: yeah (.) yeah

Student: right if i go and talk about (.) um the treatment options

Patient: yeah

Student: okay so um (.) as i’ve explained you can have some (.) that are >sort of< inside

Patient: mm

Student: um the back passage (.) some that sort of come <u>out</u> um (.) a little bit but mainly are inside >some that are always outside< (.) there’s lot of different types (0.5) and the treatment >sort of< depends on which type you’ve got

Patient: oh okay

Student: so um (.) there are lots of sort of simple things you can do (0.5) yourself um (.) so °um° so you need to (0.5) um TRY AND HAVE A HIGH FIBRE DIET↑

Patient: i take fibre gel

Student: oh do y[ou

Patient: [w-when i need it (.) well the doctor first gave it to me

Student: oh okay

Patient: um but now i just have it when need it so i just get it from the chemist when (.) when i need it

Student: okay (.) okay (.) well that’s good (.) um so that should help (.) you (.) sort of um (.) to (.) not be constipated really (.) and um are you okay there you seem [a bit

Patient: [yeah (.) just a bit

Student: >if you< if you want to stand up or anything please=

Patient: =no as long as i can just

Student: are you okay

Patient: yeah

Student: okay (.) um (.) and (.) um (.) if you drink lots of water (.) that also helps

Patient: okay

Student: umm (.) and if you eat lots of fruit and veg

Patient: yeah we do (.) do that but not i wonder if i drink enough water

Student: okay (.) if you can try and drink (.) about two litres a day

Patient: oh cor

Student: which >sounds a lot< but it really sort of helps to sort of

Patient: flush

Student: flush you out and (.) it it does help

Patient: oh okay

Student: so that’s a good thing that you could do (.) um (.) so they’re the sort of simple things that you can do (.) um you may have heard of the >sort of< creams that you can buy from the chemist or the pessaries

Patient: no

Student: okay (.) um they they’re sort of creams that you put on the area (.) um (.) they’re (.) they don’t actually treat the haemorrhoids they just sort of (.) numb the pain a bit

Patient: oh well that would be helpful

Student: okay

Patient: yeah

Student: well um (.) there are many sort of (.) they’re like little anaes-anaesthetic ↑sort of creams ↑↑that you can get (.) um just pick them up in the chemist

Patient: ok[ay

Student: [um (.) they may help your sort of (.) just day to [day

Patient: [day mmm

Student: if it’s (.) just while we-we’re getting the sort of definitive treatments

Patient: yeah yeah

Student: um (.) and then there is um (.) some more sort of more kind of (.) permanent treating

Patient: mmm

Student: sort of things we can look at (.) um (0.5) they can inject (0.5) into the haemorrhoid

(.) which sounds painful [but (.) it shouldn’t ↑be

Patient: [↑mmm

Student: um (0.5) and that (.) sort of makes in shrivel up >and disappear< (.) so um (0.5) that is an option

Patient: mmm

Student: there’s um (.) another option is um (0.5) where we can (.) put sort of a rubber ↑band over ↑↑it

Patient: yeah

Student: so it sort of (.) um (.) stops (.) umm (.) the blood getting to it (.) and then again it’ll shrivel up and sort of

Patient: right yeah

Student: disappear (.) um (.) or (.) and they’re sort of done in a clinic (.) you don’t have to have an operation or anything

Patient: mm

Student: um they’re quite simple (.) or (1.0) um if none of those work (.) then there’s (.) umm an option to have an oper↑ation

Patient: mm

Student: where they actually just (.) cut (.) the haemorrhoids away (2.0) how do you feel i-i know i’ve just given you a lo-an [awful lot of information

Patient: [yeah well really my main (.) well what i’d really like in a perfect world is to (.) have something that makes them go away (.) completely

Student: that’s yup that’s understandable (.) yup

Patient: um i-i (1.5) surgery wouldn’t be my first choice (.) in all honesty=

Student: =okay

Patient: but having said that (0.5) if that was to be the one that would <u>definitely</u> get rid of them (.) i would consider that i think (.) but °the° the other two (.) you mentioned (.) you said that (.) they should also (.) make them

Student: yes (.) yeah

Patient: go away (.) so maybe (1.5) um (.) °°maybe that (.) maybe they°° (.) i don’t fancy the injection (1.0) again (.) i am quite desperate now so i don’t think i can be too picky about what (.) y’know what i do

Student: °°okay°° well as i said the the the two sort of the injection and the banding

Patient: hmm

Student: they’re done (.) under local anaesthetics=

Patient: =right

Student: you won’t have to take any time off work or anything (.) which might be [an issue with yourself

Patient: [mmm

Student: and the operation is more sort of (.) you’re gona have to be a couple of days at the hospital (.) and it’s more for sort of (.) really severe (.) ones

Patient: okay

Student: we sort of (.) keep it for (.) <u>but</u> (.) um (1.0) they will they will treat the haemorrhoids but unless you sort of manage your (.) kind of (.) regular bowel movements=

Patient: =yeah

Student: they could come back

Patient: okay

Student: so that’s something to think about

Patient: yeah i think (.) cos we do (.) >we do eat fish< but we don’t eat meat

Student: okay

Patient: um so we do eat plenty of (.) like veg and [stuff like that

Student: [yeah (.) that’s really good

Patient: i think i think the IBS problem (0.5) for me obviously is something [that doesn’t really help at all

Student: [yeah ( ) okay

Patient: but i think drinking more water might be a good idea

Student: so what do you think then (.) what shall we (0.5) go for

Patient: umm (.) <i think> (.) first of all i think i’d like to try the one (2.0) not the injection [what was the other one

Student: [okay the banding

Patient: yeah if if you think that would make them go away

Student: ↑yup

Patient: i think maybe i’ll (.) i’d like to try that it sounds a little less (0.5) painful than the inject-i [mean i know you said they’ll give me an anaesthetic

Student: [yeah

Patient: but it (.) um i think maybe that (.) [that might be a good one

Student: [okay (.) that’s a good idea (1.0) and if you also try the sort of sim- the simple measures i told you about

Patient: yeah definitely

Student: and i really think

Patient: definitely

Student: you’ll see an improvement (.) and i hope (.) umm (.) hopefully get treated soon

Patient: yeah (.) °yeah°

Student: okay well um (0.5) i’ll pass on a-all that information for you ( ) if that’s okay

Patient: yeah

Student: and GOOD LUCK (.) i hope you er (.) get it sorted [soon

Patient: [thank you very much (.) thank you

Participant 012

Student: so (.) hi there (.) jamie↑

Patient: uh (.) saunders y[es

Student: [saunders nice to meet you mr saunders (.) er my name's (.) jason jones (.) i'm one of the fourth year medical students here

Patient: right

Student: a::nd your GP doctor ma:rtin (.) has just asked me to come and have a chat with you today (.) cos i understand you've (.) had a <bit of news recently>

Patient: well i-i-i had some kind of (.) sigmoidoscopy at the hospital yeah

Student: yeah okay (0.5) so you're happy to proceed

Patient: yeah i mean if i-if it's helpful to you (.) my niece has actually just um (0.5) started studying medicine at [at durham she says it's very useful

Student: [oh right

Patient: to talk to (1.0) patients

Student: well thank you very much for coming in

Patient: no i am

Student: just before we start just to remind you that anything we say is confidential between (.) you me and the team looking after you

Patient: okay

Student: is that alright

Patient: yeah yeah

Student: are you sitting comfortably

Patient: hhh. £yeah reasonably yeah£

Student: yeah (.) um so just from my point of view i understand you went up to the hospital (.) and then you had (.) um they did some investigations >they had a quick look n<

Patient: yeah

Student: and you recently had (.) haemorrhoids diagnosed

Patient: that's it °yeah yeah° they said they were grade two

Student: grade two yeah (.) okay so (1.0) just from your perspective (.) would you like to bring me up to speed about what's been going on (.) what's been going through your head

Patient: okay well i mean (.) the thing is <u>that</u> (.) i've had something like IBS >i think it is IBS<

Student: okay

Patient: about twenty years (.) y'know and um (.) i just realised about eight years ago >cos there seemed to be lots of stuff in the press about it< that's probably what i had

Student: okay

Patient: so i've always had like constipation or or diarrhoea y'know and that's (.) bad enough

Student: yeah

Patient: n then (.) um

_____

|

(ø) (1.5)

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Student: _____ tough

Patient: yeah well (.) thanks i mean i (.) i realised that (.) hff things had got a bit worse i mean (.) especially about six months ago (0.5) ummm i-it just became very painful down there (.) very painful (.) and and i just started to get (.) bright blood on >on the toilet paper< as well

Student: i imagine that was probably quite scary

Patient: fff it was yeah (0.5) didn’t know what was going on really

Student: okay (.) so (.) you mentioned that um someone told you you’d got grade two °haemorrhoids°

Patient: mmm (.) was the consultant (.) yeah

Student: that was the consultant okay so (.) what is it that you understand about that and (.) how that might relate to what’s been going on

Patient: um i d’you know he he was (.) not really (.) great with people skills and i mean i (0.5) i gather it’s something to do with blood vessels but i mean i don’t really know very much about it

Student: okay (.) so (.) what would be most useful for me to go through with you (.) today

Patient: if you could tell me what that means and i suppose (.) why i’ve got them and what i can do about them (.) and is there something i can do just to (.) clear them up

Student: sure

Patient: that’s what i want to do yeah i want it to get them (.) sorted out

Student: absolutely i can understand that

Patient: yeah

Student: it’s not a nice thing

Patient: no it’s not no

Student: okay (.) so (.) why don’t i first of all start off by explaining to you and we’ll try and get clear in your head what’s actually going on (0.5) um and i can talk about some of the treatment options↑ that are available to you

Patient: alright

Student: um (0.5) but just before i start i just want to clarify a couple of questions °°in my head°° that will help to determine what treatment would be ↑best suited for you

Patient: yeah

Student: okay so (.) you mentioned you’ve got IBS do you ever get pain with that

Patient: um (1.5) d’y’know i mean obviously i’ve got pain around my rectum

Student: okay

Patient: with it (.) um now (.) i mean before it’s just like a sort of constant (.) y’know you might have to run to the toilet might have constipation (.) it wasn’t really (.) all that pain it was a bit uncomfortable

Student: k (.) do you ever take any ↑pain killers

Patient: not not really only for headaches and stuff like that

Student: okay (.) what do you take

Patient: um i take ibuprofen

Student: you take ibuprofen

Patient: yeah

Student: okay (.) alright (.) and um how old are you °sorry°

Patient: i’m fourty three

Student: you’re fourty three (.) okay (.) so (.) could i just (.) i don’t think that’s really going to affect anything but i’ll tell you what haemorrhoids are

Patient: okay

Student: um (.) you ss understand it’s something about veins is that right

Patient: yeah well blood vessels i think yeah

Student: well that’s absolutely right

Patient: yeah

Student: um (.) around your rectum and around your anus (.) there are a network of (0.5) er what we call CAPILLARIES (.) you ever heard of that

Patient: sure

Student: so it’s where sort of where the arteries and the veins sort the blood taking uh s- sort the vessels that take the blood to your heart and from your heart[

Patient: [oh right

Student: places meet (.) and they can exchange nutrients and things like that

Patient: right

Student: there’s a whole network around your anus and (.) what we think happens in haemorrhoids is when you’ve got an increased pressure (.) like from constipation

Patient: oh right

Student: that’s probably[( )

Patient: [right oh yeah yeah

Student: sss they distend they sort of swell up (.) you get those little lumps

Patient: yeah

Student: um and (.) they’re quite fragile so sometimes they bleed

Patient: oh right

Student: and um (.) what grade two means is (.) that (.) they’re there (.) um and sometimes they’ll actually come out

Patient: yeah

Student: i don’t know if [that’s happened

Patient: [yeah that’s yeah sort of protrude out yeah

Student: yea s-s-not the nicest thing

Patient: no (.) it’s a bit (.) embarrassing (1.5) as you can imagine

Student: it’s absolutely nothing to be embarrassed about i can understand (.) that’s it’s not the nicest thing to think

Patient: yeah (.) yeah

Student: but (.) it happens (.) and they’re very common (.) really (.) and because they’re quite fragile they can cause pain and things like that (.) does that clarify what they told you

Patient: yeah (.) yeah so they can obviously get worse than that or

Student: yeah (.) well (.) there’s four grades (.) whether or not it’ll progress it’s difficult to tell but without treatment (.) more than likely it might get a bit worse where they’re (.) just hanging out all the time (.) and might even warrent more drastic (.) °°measures°°

Patient: oh right

Student: but obviously this is (0.5) impacting on your life quite a lot (.) you seem quite upset about it

Patient: yeah yeah

Student: so i think we should probably talk about what you could do for them

Patient: >yeah yeah i mean< (.) that would be useful yeah

Student: okay (.) um has anyone talked to you about any of the options available

Patient: not-not re::ally (.) i think i heard of a ( ) had bands put on them

Student: okay (.) okay (.) so that's one of the more (.) that's one of the surgical options

Patient: yeah

Student: but generally we like to start with the conservative or the medical (
)

Patient: yeah yeah

Student: is that what you were ↑hoping for

Patient: well y'know i'm so frustrated by it obviously i want to get it sorted out but i don't want anything (.) well y'know d'y if you just tell me what the options are and i'll (.) make a decision based on that

Student: so (.) are you a bit reluctant about having surgery

Patient: well nobody really likes to have surgery do they but i am getting to the point where i think something's got to be done (.) y'know

Student: okay (.) okay

Patient: yeah

Student: well there are lots of things we can do (.) and hopefully (.) they'll make quite a drastic improvement for you

Patient: mm

Student: and get this off your mind (.) okay (.) um (.) so with IBS because you get kind of variable the stool consistency is very variable (.) what we want to do is to optimise it we want to get all of that pressure

Patient: yeah

Student: that's causing them to (.) distend swell things like that

Patient: okay

Student: so what we recommend is to drink lots of ↑water

Patient: yeah

Student: so we recommend about two to three litres a day

Patient: really every day

Student: yeah

Patient: ss a lot

Student: it is a lot (.) um (.) but y'know if it's going to make a d[ifference

Patient: [yeah sure okay

Student: um (.) you will pee most of it out (.) but more will get in to more of your stools[and it'll soften them

Patient: [right ( ) okay

Student: um (.) the other thing is to eat lots and lots of fibre

Patient: right

Student: so (.) eat lots of fruit lots of vegetables=

Patient: =my diet’s quite good actually well i think it is i don’t eat meat (.) um

Student: okay

Patient: y’know i-i eat vegetables and fish

Student: do you get your five a day

Patient: i would say most days yeah yeah

Student: okay (.) okay (.) so if your diet’s (.) and it doesn’t sound like that’s the problem (.) you could supplement it with fibre so uh a fibre tablet (.) if that’s er

Patient: i-i i sometimes i mean the doctor gave me fibre gel in the past

Student: yeah

Patient: and i sometimes buy stuff you know from holland and barrett[

Student: [yeah

Patient: just a (.) similar kind of thing (.) um but i don’t i don- i just take it when it gets bad i mean (.) i suppose i could take it more often

Student: okay did you find that it helped at all

Patient: yeah i think it did actually

Student: so maybe that’s something [you could ( )

Patient: [there’s nothing more serious about it you think maybe

Student: see if that fits into your (.) life

Patient: yeah i mean there’s no reason i mean i was just i haven’t it’s not horrible to take i think so i could do that

Student: okay (.) um (.) so the other thing is >and this might< be a bit embarrassing but (.) it’s just us here so you don’t have to feel embarrassed at all

Patient: okay

Student: and it’s completely natural (.) once you go to the toilet (.) when you get the urge to go

Patient: yeah

Student: don’t resist the temptation (.) to hold it in >i mean< don’t hold it in

Patient: right

Student: so don’t resist going to the toilet (.) just go (.) um

Patient: sort of when you feel like it

Student: when you feel like it yeah cos (.) the more you hold it in (.) the har-the more water gets pulled out (.) cos your body wants to keep water (.) and so your stools are actually harder and more difficult to pass

Patient: okay (.) yeah

Student: i understand you find it difficult with your IBS

Patient: well yeah i think sometimes you feel like you wana go and then you try and you’ve got constipation and other times you really do need to go

Student: do you find that you’re (.) when you’re on the toilet you’re straining quite a bit↑

Patient: yeah i have done yeah (.) yeah (.) cos you think well i feel like i need to go (.) just stay until i can go

Student: yeah sure (.) um well that is something that we want to avoid (.) so is there

anything we can do to help you to avoid that

Patient: yeah

Student: is there anything that would help you

Patient: to-to

Student: to stop you having to strain

Patient: no i mean i just need to be a bit more aware i think if i’m (.) i’m actually doing it y’know i get frustrated sometimes

Student: yeah i can imagine

Patient: yeah

Student: okay (.) um (.) just quickly um as time is running out um (.) the other options are surgical but you said you’re not keen (0.5) i’ll give you some information and you can perhaps go away and have read up on it (.) one is the band surgery where we put a band around it and it will (.) die in essence and come off you (.) the [haemorrhoid

Patient: [right

Student: um or there are other injections that we can put in there that causes them to shrivel up

Patient: yeah

Student: okay (.) um but as you’re not so keen on that i’m not going to dwell on that too much (.) but here is lots of information

Patient: okay

Student: have a read of it at your own pace (.) if you’ve got a[ny other questions

Patient: [can i just ask i mean is the (.) could it be (0.5) something like a sign of something worse

Student: um (.) i probably should have asked you that before but um (.) it’s usually a sign of (.) the constipation more than anything else (.) i-i-if it does change at all then you do have to worry

Patient: right okay

Student: is there anything in particular that you were worried about

Patient: well just (.) worried that (.) my dad had a bleeding from his (.) y’know backside and (.) it turned out to be colon cancer

Student: i’m sure that’s quite scary

Patient: well yeah

Student: has that been playing

Patient: i mean it’s at the back of my mind yeah

Student: okay um well because you’ve been examined they will have looked for that (.) cos that is one of the differentials (.) one of the causes

Patient: right when they had the camera up

Student: they will have looked for that and (.) as far as i gather they didn’t see any evidence of that

Patient: [no

Student: [so (.) um and they will treat it ( ) piles which is the most common cause (.) okay

Patient: right

Student: um we’ve gone through a lot today (.) and it is a lot to take on (.) if you’ve got any other worries don’t hesitate to come back and have a chat with us

Patient: oh right

Student: okay and (.) gone through the treatment options we've (.) hopefully clarified in your mind what haemorrhoids are (.) is there anything else we can

Patient: oh well (.) i mean so to stop me getting them again (.) i've got fibre gel

Student: yeah

Patient: erm (.) and not strain (.) and other treatments

Student: and lots of fluids

Patient: yeah

Student: try that and come back in a few weeks and see how that's getting on for you

Patient: okay

Student: well thank you very much for coming in today (.) um i hope that's helped

Patient: yeah thank you

Student: and here are your leaflets (.) okay (.) thank you

Participant 013

Student: hello (0.5) is it mr saunders

Patient: that’s right (.) y[eah

Student: [hello pleased to meet you sir my name’s michael man i’m a fourth year medical student

Patient: [nice to meet

Student: [i’ve been asked to speak to you by your doctor (0.5) is that alright↑

Patient: uh yeah that’s fine yeah

Student: okay (.) so what i’ve been told is that um (.) you’ve had some (.) haemorrhoids down below

Patient: yeah

Student: and um (0.5) i’ve been asked to speak to you about some (.) some possible treatments for that (0.5) is that alright

Patient: yes yes that would be useful yeah

Student: so just to let you know anything that we do talk about today is confidential between (.) ourselves and (.) the doctor (0.5) um (.) so er (.) can i start off with wha-what so what’s been going on↑ (.) with (.) with regards to haemorrhoids

Patient: well (.) with regards to that i mean um (.) i came to see dr anderson (.) six months ago cos they were really (.) getting quite bad

Student: mhmm

Patient: and over the last six months it (.) it has been quite bad

Student: [okay

Patient: [um (0.5) i've had some (.) blood on the toilet paper and been very sore i have to (.) sit on a cushion when i'm working

[you know

Student: [sure

Patient: it's all quite embarrassing really (0.5) i'm just (.) i'm really (.) hoping to get it sorted out (.) as soon as possible

Student: and have they explained to you what haemorrhoids actually mean

Patient: umm (.) well i (.) the consultants were saying it's inflamed (.) blood vessels °or something like that°

Student: yes so you've got °distended blood vessels° and um (.) is there anything you're particularly worried about that you wana talk about or

Patient: >well it's just< (1.0) [when you see blood

Student: [>anything at all<

Patient: on the toilet paper you do worry about it being something else

Student: yeah sure (1.5) and um (.) obviously i've been asked to talk to you about treatments (.) is >there um< anything else you'd like to cover or ( )

Patient: um (1.0) well er (.) i'd like it if you could reassure me that it is just haemorrhoids and that we could do something about it

Student: okay (1.5) um (0.5) so y-s-y'said that obviously you know that haemorrhoids are these >sort of< °distend° blood vessels down below (.) um

Patient: th-they're what

Student: these blood vessels down bel[ow

Patient: [yeah (.) yep

Student: that we call haemorrhoids (.) and um you've been having blood on the paper and that and that's what you're seeing

Patient: yeah they're very painful as well

Student: yeah (.) um (1.0) so i'm sorry to hear that you've been having >all these< all these problems i can appreciate it's it's very distressing ha- (.) passing blood (0.5) um (.) and your doctor has looked at you and and (.) he said that it is haemorrhoids that you have

Patient: well it (.) i mean thisss-sigmoid↑oscopy at the (.) hospital↑

Student: yes

Patient: as well i mean (.) i'm just sort of (.) he said it was um (.) grade two haemorrhoids i think=

Student: =yes (.) >and that< and that's just (.) do you understand what the grade tier means

Patient: not really (.) no

Student: okay (.) so it's just a way basically saying that those little blood vessels are just sticking out >but you've hav-you can you see or feel<

Patient: sometimes they do [come out

Student: [yeah

Patient: ( ) sometimes they don't

Student: yeah so that's that's just a way of describing their popping out °of the bottom°

Patient: so how bad could they ↑get then

Student: um (.) they get graded up to four

Patient: right

Student: and um (0.5) and the moment it (.) the grade tier is saying that yours can be pushed back but th-they generally come out quite a lot and they're causing ( ) (0.5) does that make sense

Patient: yeah that i-that's what's happening

Student: so (.) um (.) we've that >k'now< you've got these haemorrhoids y-you've had an investigation confirmed that they are them (.) um (.) ssso before we (.) move on to talk about possible treatments (.) um do you understand what the treatments are (.) or not at all or

Patient: um (.) i've heard of people having operations and um

Student: okay

Patient: and that kind of thing (.) umm no the consultant just said to talk to the GP about it

Student: so you've heard of operations but not really anything that's

Patient: no

Student: okay (.) is there anything that you're particularly worried about the treatments (.) or anything you don't want to [know

Patient: [well obviously you don't want to go through a lot more pain y'know especially if there's not (.) a good result i mean (1.0) favourite option would be >if we were to< get it sorted out fairly quickly and not have to worry about it anymore

Student: okay

Patient: so it's not affecting my work and i can just (.) enjoy myself

Student: u-um (.) and (.) so it seems to me that y-
you're saying that <you> you wana get it
fairly sorted out↑

Patient: yeah

Student: because it's bothering you at work and
stuff

Patient: yeah

Student: but what you don't want is to do something
and then it comes back [again

Patient: [that's right (.)
yeah

Student: okay (1.5) well um (.) if it's alright
with you i-i'll discuss some of the
surgical things and-and we'll talk about
(.) um (.) obviously some of them aren't
perfect and we're going to have a hundred
percent

Patient: right

Student: rate where i can say no they've never come
back (.) an-and ( )
um (.) so that's the sort of surgery um
we'll talk about some of the things you
can do yourself like dietary things

Patient: okay

Student: um (.) does that sound al↑right

Patient: yes yeah (.) yeah

Student: okay (1.0) so the first thing er to talk
about is cons- what we call conservative
treatment it's stuff that you can do (.)
yourself in your lifestyle

Patient: yeah

Student: um (.) and that would be things like uh
increase the amount of fibre that you eat

Patient: right

Student: do you eat lots of fruit (.) and vegetables

Patient: well i (.) i think my diet's fairly good i don't eat meat

Student: sure

Patient: you know um

Student: so it should be pretty high anyway

Patient: <yeah> (.) and i-i the doctor told me t-to take fibre gel sometimes=

Student: =yes (.) that's fibre you take can (.) separately from (.) °°the fruits and vegetables°° (.) so that that's that (.) um (.) you can drink (.) lots more water (.) so that's another or just take in fluids generally [cos that s-softens °stool°

Patient: [how much should i drink

Student: well there's (.) no set amount it's just about (.) keeping your intake

Patient: sort of generally °quite high°

Student: <yeah> how much are you drinking on average a day

Patient: i duno i drink a lot of (.) tea and coffee really

Student: drink a lot of tea and coffee (.) okay so you probably have a enough but maybe to have a bit more water would it might help (.) um (1.0) and then when you nee-when you feel the need to go to the toilet make sure that you do go straight away cos by holding it in (.) it's going to add more pressure to it

Patient: yeah the bowel movement making

Student: yes so when you need a bowel movement just go

Patient: right

Student: and and and and (0.5) don’t hold it in (3.0) and (.) that’s about it really

Patient: right

Student: so (.) does-th does that sound like it’s

Patient: yeah the thing is i i mean i (.) i’ve had what i think must be IBS for quite a long time >maybe about uh< twenty years or so i just sort of realised about seven or eight years ago when the stuff in the press about it but whereas one minute i’ve got constipation the next i’ve got [diarrhoea

Student: [fairly difficult for you to

Patient: i don’t quite know what’s going on

Student: yeah i appreciate that yeah (.) but nonetheless they are still things you can try even though y’know (.) the IBS probably brings it out of your hands slightly

Patient: <yeah> do you think (.) the IBS might be part of the cause of it

Student: it could be yeah that’s very li-like you said it changes your bowel habits and things it could make it a bit more (0.5) y’know where you get times of constipation you can’t help that so (0.5) but but nonetheless i say there are certain things you can (.) °you can try° (0.5) um oh sorry the final thing is do you take things like um (.) co-codamol or any drugs like that (.) painkillers

Patient: um no not really no

Student: so is so

Patient: just a little bit of paracetamol some[times when it

Student: [yeah

Patient: it’s got quite bad when i’m going to the theatre or something ( )

Student: yeah (0.5) no that’s fine but there’s a specific drug co-codamol that can block you up

Patient: oh right yeah

Student: avoiding things like that

Patient: as a patient

Student: yes i mean speak to your doctor if you think the drugs that you’re taking can

Patient: yeah

Student: so they’re conservative things (.) and (.) um (.) before we move on to the surgical ones so things like we can do do you mind summarising the things we said you can do (.) yourself

Patient: um (.) should drink more water

Student: yep

Patient: um plenty of fibre

Student: yep

Patient: i suppose maybe get some more fibre gel and

Student: yep

Patient: that would be a good idea n avoid drugs that can (0.5) block you up

Student: yeah

Patient: um

Student: and not holding it in

Patient: oh yeah going when you just (.) you need

[to

Student: [need to yeah (0.5) okay (.) so the surgery things you can do (.) um (.) we can (0.5) a surgeon can go and and put a little band like a tight elastic band around the haemorrhoid (1.0) um and that's the main one really (.) so the other things we can do (.) um if you really don't want that are (.) w-we c (.) we can inject it (.) with a chemical which makes the haemorrhoid just drop off and that's not generally painful (.) and neither is the banding

Patient: j-do you think ri (.) they're not painful

Student: th-th-they're generally not painful no cos you've not got much sensation down there

Patient: oh right

Student: mm-it might with you cos you've got IBS so it might be more sensitive

Patient: right

Student: but the only way to completely cure these (.) um (.) shh because we could give you creams and stuff >which can talk about after< but it's not going to get rid of it which is (.) which is what we're talking about today (1.0) um (1.0) so (.) there's (.) there's the banding with the surgery (.) and (.) about eighty percent of people it works for and who won't come back but (.) in about twenty percent they can come back

Patient: right

Student: if they do they can put another elastic band on ( ) the other one is injecting it with the (.) with the chemical and that should drop off as well

Patient: right

Student: and (.) um (2.0) most people that (.) that works on (.) but it's got a ss-slightly

lower >sort of< success rate so again it could have it it's in the region on sixty seventy percent ( ) so they're two types of surgery then there's a third one where you can sort of bend them away slightly as i say

Patient: it sounds quite painful

Student: £yes it does sound painful i agree£ but um (.) down there there's not much sensation so it's just a-a-a-a y-y-you get a tiny (.) little uh probe called a diothermic (.) and right at the base of the haemorrhoid you just um (.) you just touch it >a bit like a soldering iron< you just touch it and then um (.) they'll drop off again

Patient: okay

Student: so they're fairly similar types (.) ummm (0.5) as i said they g-generally shouldn't be painful (.) but (.) um (1.5) ur they c-they could be in your case as you said you have the IBS so you've you may

Patient: complicates procedures does it

Student: uh a tiny bit i-i-they increase your chance of feeling a bit more pain yes >but but< generally it's not painful (1.5) um the only other thing to add is the third one i mentioned wi-with the heat treatment burnt off (0.5) then it's uh errr generally that's less painful (.) and um (.) they can give you an anaesthetic as well

Patient: and the heat treatment's ↑less painful

Student: it is ( ) (1.0) so just to summarise they could put a band round it (.) it's about eighty percent so about eight out of ten people it would work for (0.5) if it does come back we can just do it again (1.5) um the second one is um (.)

where we inject it with the chemical (.) again would just drop off um slightly less chance that it'll work (0.5) but again they can treat it or try something else (.) and the third one at this stage is is um is to is to burn it out a bit like a soldering iron

Patient: sure i mean it is just um (.) haemorrhoids isn't it wouldn't be anything else you know °anything that i've got°

Student: um (.) because you've had the (.) um (.) the er the scope (.) it's very unlikely to be anything else

Patient: °okay°

Student: okay (0.5) so just to make sure i've explained that clearly do you mind repeating back the three o[ptions

Patient: [so there's a band or an injection or a sort of soldering iron type [thing

Student: [yes (.) there are other things we can do if th-they really don't work

Patient: arh right

Student: or if um (0.5) if they if they come back

Patient: right

Student: but generally the chances are that it it should work

Patient: and go away

Student: yeah (.) and it shouldn't be painful but it as i said cos you've got IBS if you do have pain we can give you (.) um some anaesthetics and take that away

Patient: okay

Student: so based on what i've said (.) have you got anything any sort of impressions about (.) which one you prefer to go for or

Patient: um

Student: whether it's all too much and you don't want to

Patient: well i i'll probably if you say that none of them are too painful i'll probably go with whatever the doctor (.) the the consultant whoever is gona do everything y'know

Student: okay

Patient: they'll probably have an opinion won't they though i suppose they might differ amongst themselves

Student: >yeah i think< the third one is probably less painful and it can be (.) some people choose it for that reason

Patient: okay

Student: but (.) ummm (1.0) i think i don't think it's quite as sort of (.) successful

Patient: right

Student: but as i said if it can be the case or they just come back (.) cos they might do then you can always (.) come back to the drawing board an-and (.) there are lots of other options >but at this stage< generally they're the main three

Patient: okay (.) thank you

Student: alright so (.) do you want to go away and think about it or or have you got any thoughts on them

Patient: well (.) i think i'm going to book in and just sort of get it sorted out really

Student: that's fine

Patient: yeah (0.5) if that’s possible

Student: yeah

Participant 014

Student: >hello is it< miss saunders

Patient: yeah

Student: hi um the GP’s asked me to see you today (.) um i understand you’ve (.) been having some problems and um (.) i just really want to find out a little more about that if that’s okay

Patient: that’s fine yeah=

Student: =everything we talk about’s gona be completely confidential (.) the only person i’ll talk about it with is the GP and that’ll just help your care a little bit

Patient: gr[eat

Student: [is that alright

Patient: yeah that’s fine

Student: can you just tell me a little bit about your problems and what’s been going on

Patient: well (0.5) um well six year-months ago i came to see um (.) the GP because (.) i was in a lot of pain

Student: mmmkay

Patient: and uh also umm (.) i’d been having some °°bleeding°° from

Student: righ[t (.) okay

Patient: [the back passage (0.5) and he was quite concerned about that (.) so um (.) um he referred me (.) to the hospital

Student: right

Patient: and ummm (2.0) and i had one of these (.) uh (.) umm (.) sig-sigmoidoscopies

Student: okay

Patient: down there (.) and um (.) and the consultant there told me (0.5) uh that he thought it was (.) eh (.) haemorrhoids

Student: right okay

Patient: and um (1.0) and so basically today i've just come back to have a talk (.) hopefully have a chat about y'know what the next steps are [really

Student: [okay (1.0) okay (.) um (.) so for the last six months (.) you've been having pain

Patient: well it was the bleeding that worried me (.) more than anything else but over the last six months since then (.) it's just been (.) excruciating i can't tell you

Student: ah i'm sorry to hear that (1.0) uh is anything that make it better >or worse< at the time

Patient: well (0.5) nothing seems to make it much better to be honest i've i've start[ed cos i work at home

Student: [right mmm

Patient: and um (.) we er (.) we got me a little °this is little circular cushion°

Student: right

Patient: to sit on (.) cos i spent a lot of time sitting

Student: right

Patient: and it's (.) so (.) bad (.) that um i've been sitting on this sort of circular cushion and (.) it makes it bearable but it really doesn't (.) make it better

Student: okay then

Patient: no

Student: and um (.) going to the toilet do you find that very painful[l

Patient: [yeah

Student: right (.) and how often do you go to the toilet

Patient: well it’s (.) i-it’s it’s always different because um (.) because i suffer a little bit wi-with IBS

Student: right okay

Patient: y’know i go through good times and [bad times really

Student: [mmm

Patient: so um (.) it can be different every day

Student: right i see (0.5) so the IBS varies day to day

Patient: it can do yeah or sort of week to week i mean i’ve the doctors (.) i sort of diagnosed myself really about eight years ago [cos there was a lot in the papers about it at the time

Student: [right right okay

Patient: and i thought >oh god that’s< cos i’ve always had these crampy fee[lings

Student: [uh-huh

Patient: and i came back to the doctor then and he gave me some fibre gel

Student: oh ri[ght

Patient: [to use (1.0) umm (0.5) and that sort of helps a ˚little˚ bit i think

Student: okay

Patient: it’s either sort of one thing or the other and neither of them’s seem really good

Student: okay so how often a day would you go to the toilet

Patient: well (.) i can be (0.5) well i can be °constipated° or (1.0) it will go completely in the opposite direction and i >sort of< (.) y'know i can (.) i can have diarrhoea and it so if it's like that obviously it's more often

Student: right (.) okay so i'll just kind of summarise that and then we'll move on

Patient: mmm

Student: and to talk about some treatments so for the last six months (.) six months ago you noticed that you had some bleeding

Patient: yeah

Student: and (.) you had some pain as well (.) and you went to see your doctor

Patient: mmm

Student: um (.) you had a sigmoidoscopy and you were diagnosed with haemo↑rrhoids

Patient: yeah

Student: okay um you've also got a (.) past medical history of IBS and you take a fibre gel °for that°

Patient: yeah i think probably i've had it about twenty years [at least

Student: [the IBS

Patient: mhmm

Student: okay (.) um and that um (.) your bowel habits (.) [fluctuate (.) depending on bowel habits

Patient: [they really do

Student: okay (.) um j-just one question before we move on (.) when you do go to the toilet

(.) is it very (.) hard your poos (.) or is it

Patient: >sort of< according to how i am on that day (.) you know whether i'm constipated or not really

Student: okay (1.0) alright um (0.5) can you tell me (.) what do you know about the treatments or any treatments you'd prefer [or

Patient: [well i (.) i don't know anything about treatments at all

Student: [okay

Patient: [i'm really hoping that there's something that can make it go away

Student: right

Patient: that's what i'm really hoping for i-i (.) i don't even know (.) really what they are

Student: [oh right okay (.) we can start there

Patient: [or have i done something to sort of bring them on really

Student: okay (.) um (.) so haemorrhoids are um the veins that surround uh the anus (.) what happens is (.) um when we defic-when we have large poos (.) when somebody's pregnant what can happen these can uh (.) these can increase in size (.) around the anus and what happens i- (.) over time they can become enlarged an-and they can form a haemorrhoid which is just like a small outpouching (.) of blood (.) it's filled with the (.) with eh (.) this vein (.) and uh

Patient: so that's th[e haemorrhoid

Student: [that's the haemorrhoid (.) sometimes they're inside (.) and uh from what i've read in your notes yours was a grade two

Patient: mmm

Student: so what happens there is >they're actually inside< so you can't feel them externally (.) but when you go to the toilet (.) they will actually come ↑out

Patient: yeah

Student: and then when you've been they'll go back in (.) um so (.) they're graded between one and four >so yours are kind of< they're not the most severe (.) but (.) but ( )

Patient: which is the most severe out of

Student: well some-

Patient: from one to four then

Student: four is sorry is the most severe [and that's when that's when they're on the outside

Patient: [↑rea↓lly

Student: so they can get back in

Patient: but i'm only a grade two this is awful

Student: i know so imagine (.) they can be more painful but they affect everybody slightly differently (.) doesn't take anything away from how painful [yours are

Patient: [well no it doesn't i know how bad it is but i can't that's unbelievable

Student: um (.) good thing is that (.) there is something (.) we can do (.) about it [they are (0.5) curable

Patient: [yeah

Student: um it is a curable disease (.) um (.) there are (.) different types of treatment >some are conservative treatments< and there's also a surgical treatment as well

Patient: right

Student: so which of them would you prefer to (.) talk about

Patient: um (1.0) uh

Student: [surgi-

Patient: [well (.) i'd prefer not to have surgery [but if that's the only way to go to make them go away forever

Student: [right

Patient: then i wou-really i would consider that now (.) but if there's something else we can try before that then i'd be happy to try that

Student: okay (.) um (.) surgery is a definitive treatment um it will get rid of them (.) but there are things that you can do (.) and it depends how many of these things you're already doing

Patient: right

Student: how effective they will be for you

Patient: right

Student: um so they're things like increasing the amount of fibre in your d-fibre in your diet

Patient: right

Student: um (0.5) and it's the right type of fibre as well that you need in terms of fruit and vegetables and cereals

Patient: right

Student: mmk (.) um (.) there's things like drinking lots of water and what that does (.) that helps prevent having really hard poos

Patient: ri[ght (.) right

Student: [plenty of water and staying hydrated

Patient: right

Student: so these are simple things that you can do to try and prevent them (.) err getting any worse it won't cure what you've already got but it'll stop (.) future ones occurring

Patient: getting worse

Student: i-in future yeah (.) um we could give you some fibre supplements as well uh that would also help depending what your diet's like [now

Patient: [okay

Student: um and (.) things like avoiding codeine which can cause constipation codeine's a ↑pain killer

Patient: mmm

Student: um it can cause constipation

Patient: oh right

Student: and (.) build up of uh

Patient: i don't think i just take paracetamol

[if i have a

Student: [paracetamol

Patient: cold and things

Student: mmk well it's just a thing just to remember to [avoid having paracetamol or codeine as well

Patient: [right (.) no it's very useful (1.0) yep

Student: um (.) and then uh (.) toil-in terms of toileting (.) um if you implement these things (.) and you try and >as soon as you get the urge to go to the toilet< you

actually go you don’t kind of (.) [hold on to it

Patient: [hold it back (1.0) right

Student: because that’s going to compound and make the quantity worse

Patient: okay right

Student: um (1.5) there are also thing like suppositories (.) uh uh things you can put up the back passage to help try and shrink it down as well i’m not sure how you feel about that

Patient: i think that would be a bit (0.5) i think that would be really sore

Student: yoo-vee um (.) it possibly would be a little bit sore but um (.) it i-it helps um (.) shrink down (.) the haemorrhoid

Patient: inside (.) like

Student: yeah so that would shrink it down at the time (.) and if that’s not effective (.) then (.) there’s always the surgical option (.) um

Patient: right (.) well uh what’s that then

Student: um the surgical option’s uh (.) i think it’s called a ↑banding procedure

Patient: mm

Student: uh (1.5) they um (.) there’s a (.) you go to a hospital >it’s just a day procedure<

Patient: yeah

Student: and it’s (.) just have some local anaesthetic (.) i can see you’re really uncomfortable there

Patient: i am

Student: are you alright

Patient: i am uncomfortable

Student: do you want to have a [break or

Patient: [i-i'll just perch

Student: you sure=

Patient: =no i'm no alright yeah (.) yeah

Student: um so with banding (.) and so they (0.5) it's a device they it's very hard to explain

Patient: ah

Student: but it's i-it's a very good procedure and it's very effective

Patient: i mean that's surgical this is

Student: it is surgical but it's i-th-a local anaesthetic you don't th-that's a small injection (.) near your anus (.) um a device kind of grab the (.) umm (.) haemorrhoid (.) and then a band is inserted over the top of it (.) and then it just (.) comes off (.) and then they just ligate it to close it up

Patient: right

Student: so (1.0) it's a very good it's a fairly new technique >it's only been out sort of two or three years< uh but they've been having fantastic results with it

Patient: okay

Student: um (0.5) you would after the operation i would imagine you you would be sore for maybe it's a week or two

Patient: mmm

Student: as it started to heal over (.) you might get a little bit of bleeding as well (.) but it is it removes the haemorrhoid

Patient: well if it’s going to make them go away that’s what i want really

Student: that’s what you want

Patient: yeah

Student: well okay (0.5) how do you feel about all them options which [one would you like

Patient: [well i’m happy to try anything to help myself

Student: hmm

Patient: y’know i’ll try any of those things that you sug[gested

Student: [yep

Patient: um (0.5) but i would really like to have something (.) you know (.) quite positive done i think [to make them go away

Student: [well okay (.) how about we fff-i speak to the GP

Patient: yeah

Student: and (.) with the the view we try and get you referred to the hospital=

Patient: =yeah

Student: you could speak to one of the surgeons up there they can (.) have a look and they can give you a little bit more information about the surgical procedure

Patient: okay

Student: and then um (.) we’ll take it from there how [does that sound

Patient: [that’d be great (.) yeah

Student: okay and is there anything (.) in the meantime in terms is there anything we could do to try and manage your pain

Patient: well if you could just gi-write down a few of those other

Student: yep

Patient: easy options that i can do myself then i'll definitely have a go

Student: few additional things i'm not sure if you've tried them you could always fill a hot water bottle with hot water or with cold water and sit on it=

Patient: =what just to sort of

Student: to sit on some people prefer hot water some would prefer ice cold water

Patient: i'd try anything

Student: just to try

Patient: yeah

Student: the amount of pain

Patient: yeah (.) okay well i'll

Student: and if and if in the meantime while you're waiting for this referral the pain gets (.) excruciating if you come back there are more things that we can give you to try

Patient: to try and help

Student: take the pain off you a little bit (0.5) okay

Patient: yeah thank you very much

Student: it was very nice to meet you

Patient: thank you

Student: thanks

Participant 015

Student: mrs er jane saunders

Patient: yes

Student: hi (.) good afternoon (0.5) uh my name’s nadya khan and i’m a medical student (.) and i’m here to talk to you >did doctor martin mention that<

Patient: yes

Student: okay (.) are you still happy to carry on

Patient: that’s absolutely fine [yeah

Student: [okay (.) brilliant (0.5) um before i start i just want to let you know that anything you do tell me is going to remain completely confidential

Patient: okay [right

Student: [okay (.) aaah so can i start by asking (.) uh your age please

Patient: fourty two

Student: okay and can i ask you what do you work as

Patient: um::m-my husband and i (.) we have a book binding business

Student: sure (.) okay (.) right (.) so whatchyin today then

Patient: um >what uh well< i was hoping today (.) that we could talk about (.) about um >y’know< what’s gona happen next after [the tests i had at the hospital

Student: [sure (0.5) okay (.) okay

Patient: about the (.) the the um [°°haemorrhoids°°

Student: [the problems

Patient: yeah

Student: okay before uh (.) okay you want (.) we will definitely talk about the tests that you had done um (.) two weeks ago is that correct

Patient: mm

Student: okay (.) ummm before that can we talk a bit about what actually happened (.) why did you actually have to have those tests done

Patient: right (.) well (.) um about six months ago (.) came in to see my GP (.) because (.) i noticed (.) well i knew that-that i was really >sort of< sore down below

Student: sure

Patient: um (.) but also that there was (.) a bit of (.) °blood on the° on the tissue

Student: mm

Patient: on the toilet paper

Student: okay

Patient: and i was quite concerned so i came to see my doctor

Student: mhmm

Patient: um and that’s when he referred me (.) to the hospital

Student: okay

Patient: um at the time he (.) he suggested that he thought it was probably

Student: mm

Patient: haemorrhoids

Student: right

Patient: and um (.) but he thought that i needed to sort of get it checked

Student: of course (.) of course (1.0) your concerns about bleeding is completely understandable (.) mm you’re sitting a bit um (.) are you comfortable enough

Patient: well i-like i’m alright i’m just (.)

sor[e (.) to be honest

Student: [sure (1.0) yup (.) <okay> (.) okay umm (0.5) apart from having this problem with your back passage do you have any other past medical history

Patient: um (.) i think i’ve got some IBS

Student: okay

Patient: i got well (.) i think probably i’ve had that for (0.5) probably twenty years

Student: okay

Patient: um but it was it was only seven or eight years ago that

Student: mhmm

Patient: there was a lot of it in the newspapers at the time that made me think oh (.) i think that’s probably what i’ve got

Student: okay

Patient: and um (.) the doctor (.) then um gave me some fibre gel (.) to use

Student: right (.) okay

Patient: um (1.0) but d’ya know i don’t always have it (.) if i need it now i just have it

Student: right (.) okay

Patient: over the counter yeah

Student: and did that actually help you with your IBS or

Patient: it does i think but (.) it’s sort of (.) swings and roundabouts because one minute (.) i-i i can be ˚quite constipated˚

Student: okay

Patient: but then sometimes it goes

Student: okay

Patient: the opposite way

Student: ri:ght so it’s been like that since eight years [constipation

Patient: [over eight yea[rs yeah (.) yeah

Student: [over eight years

Patient: yeah about twenty years probably

Student: okay yeah okay so that’s a long time of having constipation and dealing with it actually

Patient: well and either that or (.) y’know

Student: okay

Patient: yeah yeah

Student: right (.) okay (.) is there any other condition that you take regular medication for

Patient: no

Student: okay (.) do you take anything else uh uh u:::h occasional (.) fibre gel

Patient: no

Student: no (.) okay (0.5) umm is there any allergies do you have any allergy anything like that

Patient: not that i’m aware of

Student: okay (.) um (.) is there any family history that you have (.) any disease any bowel disease lung disease

Patient: um well my dad (.) he had uh problems with his bowel (.) he had bowel cancer

Student: i'm so sorry to hear that

Patient: um and he had an operation when he was sixty (2.0) um (0.5) and it seemed to go well at the time but unfortunately (.) um he (.) eighteen months later he did (.) pass away

Student: i'm so sorry

Patient: so um (1.0) that has been a bit of a worry

Student: okay why is it a worry

Patient: well because i know that he had some bleeding (.) from the back [as well

Student: [okay (.) and okay (.) so you considering that <u>you</u> have the same problem (.) could be [the same as your dad had

Patient: [yeah

Student: has that played on your m[ind

Patient: [it has a bit even though i've been to the hospital and i saw that doctor i

Student: yeah

Patient: i think probably (.) it's still at the back of my mind yeah

Student: were you going to voice your concern when you saw the consultant at the hospital

Patient: wasn't really he was a man of few words to be honest

Student: right okay (.) ummm (.) can i now move on to some lifestyle questions

Patient: mm

Student: is that alright

Patient: mm

Student: um (.) can i ask (.) do you drink

Patient: yeah but not very much really

Student: how much would you say you drink

Patient: just a glass of wine with my dinner

Student: okay (.) and do you ↑smoke

Patient: yeah i do yeah

Student: can you tell me how much you smoke

Patient: err (.) probably ten or twelve a day

Student: okay (.) okay (.) umm (.) okay (0.5) right
um (.) i've collected what i what is
called a history of what has been
happening to you since (.) eh two weeks eh
(.) for the past six months as well (0.5)
ummm (0.5) you had seen the consultant in
the hospital as well you say (.) so um is
there any information that he gave you at
that point or

Patient: he w-eh-well he said that um >i had one of
those sigmuh-sigmoidoscopies<

Student: yeah okay okay

Patient: he said that he he agreed with the GP and
he basically said that h-h-he thought they
were haemorrhoids

Student: okay

Patient: and he said they were (0.5) um (.) a grade
two

Student: okay (.) yeah

Patient: i don't really know what that means

Student: okay (.) sure (.) okay would you like me
to talk about (.) the different gradings
of haemorrhoids

Patient: well if (.) yeah i'd like to know what it means

Student: okay (.) definitely (.) so um and are you happy with the (.) the sigmoidoscopy that you had and was the result as ( ) with you at that point

Patient: i think (.) well he just said that it was haemorrhoids and and not to [worry really

Student: [sure

Patient: i mean it wasn't very nice

Student: sure of course

Patient: i think the whole thing's a bit embarrassing (.) really

Student: of course it's not a very dignified[

Patient: [no exactly

Student: [examination (0.5) unfortunately in order to find out what is actually going on especially when bleeding is involved it's best to have it done

Patient: y'have (1.5) yeah

Student: but i'm so sorry it's such an undignified experience for you

Patient: yeah

Student: okay (.) so we'll talk about definitely it's a haemorrhoid you say that you had grade two haemorrhoids=

Patient: =that's right yes what they said

Student: what the consultant said (0.5) basically haemorrhoids are uh a lining (.) of er (.) your (1.0) end part of your rectum er-er part of your back passage

Patient: i see

Student: ur it is um supplied with that (.) capillaries as well (1.0) over a period of constipation for as (.) especially when there is a long history of constipation (0.5) you have to strain a lot to open your bowels (.) as you might be experiencing (.) for coup-past twenty years

Patient: yes

Student: isn’t it (0.5) eh-what that causes it-it stretches (.) the skin (.) of the back passage in such a way that it can’t actually go back to its original position (.) so then it starts to (.) interfere and come out

Patient: mm

Student: the way they >the way haemorrhoids are graded< is if the skin along with the capillaries in it (.) if it stays inside the back passage (.) um it’s graded as umm grade one (.) that means it’s not going to come out it’s going to stay where it is but it’s still there but it’s inside (0.5) grade two’s basically whenever you open your bowels (.) what part of it comes out and then when you (.) when you finish with it it goes back in (.) and then there’s another grade which is grade three which means it’s if it comes out it stays out as well

Patient: oh really

Student: yeah (.) unfortunately that that’s basically uh what grading of haemorrhoids are

Patient: i can’t believe that it could be any worse than it is cos it (.) to be honest in the last six months it’s just become absolutely ex<u>cruciating</u>

Student: °must be hard° (.) um has um how has it been affecting you you seem in quite a bit of pain at the moment as well

Patient: well it is really difficult an i mean uh (.) the problem is (.) i-i-i spend an awful lot of my time (.) sitting [at work

Student: [sure sure

Patient: um so now i've (.) what i've got on my stool at work now is a round cushion >i sit on this round cushion< cos it's the only thing that sort of helps relieve it a bit

Student: sure (.) sure sure (.) yeah that's as i said because you've got a grade two every time you open your bowels it comes out

Patient: mmm

Student: but when you're finished with it it goes back in that that's the reason because it's (.) the blood vessels are very close to the skin every time you go to the toilet they they they open up

Patient: right

Student: are you passing fresh blood

Patient: yeah

Student: and uh it goes back in afterwards (.) okay (.) are you happy with that

Patient: yeah

Student: okay (.) do you want anymore further explanation

Patient: no i i was wondering why i got the or if i'd done something to make but obviously it's just part (.) it sounds like it's part of the IBS

Student: it is because of the constant pressure in the back passage basically it’s ( )

Patient: mmhmm

Student: okay

Patient: so um (.) what can we do though

Student: there are there are treatment we can offer you (.) you can have uh certain treatments which can actually take um (.) ur it can involve changes in your lifestyle and then you can have medical treatment as well (.) which we can talk about in details (.) if that’s what you want

Patient: okay=

Student: =okay=

Patient: =yeah

Participant 016

Student: urr mr:: jamie (.) saunders

Patient: that’s right yes

Student: okay hi my name is guia carrera and i’m a medical student

Patient: right

Student: and i’m here to talk to you is that o↑kay

Patient: that’s fine yeah yeah

Student: i think before we start i’d like you to know that anything you tell me is going to remain completely confidential

Patient: okay

Student: okay (.) can i ask start by asking your age ↑please

Patient: yeah i’m f-fourty two

Student: fourty two (.) and can i ask what you work as

Patient: yeah um (.) i’ve got my own (.) book binding business

Student: okay (.) uh so what brought you in today then

Patient: um (.) well basically i’ve i came to see the doctor (.) about six months ago cos i had (.) trouble with my (.) haemorrhoids

Student: okay

Patient: um (.) and he referred me to a (.) a consultant

Student: right

Patient: had sort of a camera and so on

Student: okay

Patient: i mean really i think he may be good at his job but he didn’t tell me much about (.) what was going on so

Student: mm

Patient: i feel like i need some more information about and what can you do for me↑

Student: sure okay (.) so ummm (.) what actually did he tell you

Patient: well he just sort of said well y’know yeah (.) he said they were grade two

Student: right

Patient: grade two haemorrhoids

Student: right okay

Patient: but i mean (.) i just wonder y’know why i’ve got them an-and what i can do to get rid of them really

Student: sure sure (0.5) okay so we’ll definitely talk about how um (.) haemorrhoids (.) develop in the first place and how you can actually change it

Patient: yeah

Student: uh before we can actually do that (.) is it alright if i ask you some questions to just collect a little bit of information from you is that okay

Patient: that’s fine yeah

Student: okay um (.) so uh how long did you have this problem for °may i ask°

Patient: um (.) really i’ve (0.5) i suppose for a year or two but it’s got really bad in the last six months=

Student: =okay (.) bleeding started six months ago is that right

Patient: yeah (.) YEAH didn’t really notice it just happens all the time now

Student: =all the time now

Patient: yeah it’s more than i can really have to put up with so i

Student: okay (.) what other symp-is there anything else that you suffer from (.) anything

Patient: well the thing is i (.) i’ve had some trouble with my bowels for maybe the last twenty years and it

Student: okay

Patient: because of information on the internet and all that i mean (.) i think i’ve got IBS

Student: okay

Patient: i think that’s what i’ve got (.) i’ve got diarrhoea and next i’ve got constipation

Student: okay

Patient: i guess that hasn’t happened

Student: right (.) okay so you haven’t visited the GP about (.) abou-about it

Patient: yeah i know the GP knows [( )give me some fibre gel

Student: [oh right okay

Patient: to [take

Student: [right okay

Patient: and things like that (.) i thh when it gets sort of a bit worse y’know i usually take it so

Student: right (.) okay (.) and at the moment are you constipated (.) at all

Patient: umm >well i mean< i’m a bit the other way at the moment [to be honest

Student: [oh right okay (.) right okay (.) so you had this problem for the last two decades

Patient: pretty much yeah

Student: okay (0.5) is there anything else that you suffer from any problems with your (.) with your lungs

Patient: no

Student: okay (.) do you take anything apart from fibre gel (.) do you take any other medication

Patient: no only the occasional sort of (.) you know (.) ibuprofen for a headaches

Student: okay how often do you have to take it=

Patient: =oh not very often maybe once or twice a year

Student: once or twice >that's fine< okay um do you have any any allergies

Patient: no

Student: okay (.) and do you have any family history of any problems with your bowels ( ) or chest or

Patient: well my dad had bleeding from his bowel

Student: okay

Patient: umm (1.5) and uh >was< actually bowel cancer

Student: oh right i'm sorry to hear that (3.5) does that concern you

Patient: well-e-ya of course it's i (0.5) i've got the same symptom and the consultant wasn't very reassuring or chatty (.) y'know (.) friendly ( ) so i wonder if (.) y'know shall i get checked out [for bowel cancer or

Student: [okay (.) sorry to hear about the consultant being not so helpful and did you were you able to voice your concerns at that point=

Patient: =not to him nah i mean he was just very sort of

Student: okay

Patient: he was a bit of a sliding floor and he wasn’t (.) didn’t want a conversation he just sort of said well you’ve got (.) grade two haemorrhoids now go and talk to your GP

Student: okay (.) okay (.) sure (.) we’ll definitely come back to that as well

Patient: okay

Student: umm (.) can i ask er (.) is it okay if i ask some social questions

Patient: sure yeah

Student: um can i ask you do you uh ↑smoke

Patient: i do i do yeah

Student: can i ask how much do you smoke

Patient: um (.) up to ten or twelve a day

Student: okay can i ask do you ↑drink

Patient: uh i do have a glass of wine or two yeah probably

Student: okay (.) right (.) and can i ask with respect to your living arrangements do you live (.) by yourself

Patient: yeah uh uh um i’m married

Student: okay

Patient: and i’ve got a fifteen year old daughter

Student: sure (.) okay (.) brilliant (.) uummm (1.0) errr (.) we definitely talk about

the fact about the fact you having similar symptoms as your father had

Patient: yeah

Student: and d( ) unfortunately

Patient: yeah

Student: and then about haemorrhoids (.) so do you want me to explain what haemorrhoids are and the treatment as well (0.5) or

Patient: sure yeah just (.) tell me what i can do i mean (.) grade two is that is that very bad will it get

Student: well okay depending on the fact whether they are (.) they-that's how they are grade (.) first of all to put your mind at ease (.) if they would have found anything abnormally growing in your back passage remember when they did the camera test

Patient: would they have been looking then

Student: they yeah yeah cos because they look all around in the tube all around the tube to find out if there's any abnormal growth because bleeding is a very (.) they (.) it's the kind of thing it it makes you think (.) about different thing (.) especially cancer as well

Patient: yeah

Student: so that's why it's best to have it done (.) to find out whether where the **a** where the bleeding is coming from

Patient: yeah

Student: and **b** is there anything else going on around it >in in< in the back passage so if they haven't mentioned anything (.) ummmm that means they haven't found anything abnormally growing so you can put your mind at rest at that

Patient: okay

Student: with respect to haemorrhoids (.) because eh you said you suffer from constipation and diarrhoea intermittently for a long time now

Patient: yes oh yeah i’m sure that’s what it is

Student: that’s uhh (.) that’s one of the main reason for >for< haemorrhoids to develop because the lining inside inside the back passage or your rectum (.) is in such a way that when you apply pressure it stretches (.) over a long period of time it stretches (.) beyond its capacity (.) and can’t go back to its original stage

Patient: [mmyeah

Student: [that’s how it starts to bulk up and then the gravity starts to pull it in

Patient: right

Student: and because the blood ca blood supply right behind that part of the skin (.) uh whenever you go to the toilet (.) it starts to bleed (.) and that’s why you see the fresh blood on it

Patient: right

Student: okay

Patient: yeah

Student: have i explained myself enough

Patient: yeah i think so

Student: right okay (.) are you happy with that

Patient: yeah s’really painful

Student: right okay sure it is

Patient: mm

Student: um (.) the way it’s graded is the whether it’s still inside the back passage or whether it is coming out

Patient: yeah

Student: so grade one is basically if the haemorrhoid is still inside the back passage (.) if that’s considered painful

Patient: yeah

Student: and grade two is basically when it comes starts to come out of the passage every time you open your bowel (.) and but it goes back when you’ve finished

Patient: right

Student: so that’s basically grade two (.) and then there’s another grade which means which is grade three that means it won’t go back every time you open the bowel (.) excuse me (1.0) so that’s how basically the grading is done

Patient: so it just goes up to grade three does it

Student: yeah

Patient: a-and un dun does it (.) am i going to get worse then >is it going to get worse<

Student: well ummm (.) you can (.) there’s um certain things you can do to your diet to your lifestyle that you can (.) change it in such a way that it that you can umm (0.5) prevent it for furthering further progressing and then we can offer you some medical treatment as well which you can think about if you wana have that done

Patient: what would that be cos i am quite interested in getting it sorted out

Student: sure okay (.) so as i said with you can have some lifestyle changes like (.) can i ask how much (.) um y-y-you have a publishing business you said

Patient: y’well i bind books yeah

Student: oh okay so the does that involve a lot of moving or a lot of staying in one place

Patient: no i sit around a lot [really

Student: [okay

Patient: yeah

Student: well ummm and and and do you (.) drink a lot of water during the day

Patient: well (.) i duno i (.) i have a bottle of water a day yeah

Student: okay are you able to go through can i ask how big the is it a litre bottle

Patient: no no

Student: it’s a small one

Patient: yea

Student: and are you able to go through that as (.) or y’just

Patient: yeah i probably drink it in a day yeah

Student: okay (.) the best thing is if you can in- increase your fluid intake that would actually softens the stool so you don’t have to strain every time you go to the toilet

Patient: okay

Student: so if you can drink up to ten to twelve cups of water a day

Patient: yeah

Student: if you can do that that would actually

Patient: well it’s quite a lot isn’t it

Student: but that’s basically a person needs to drink that amount of water everyday anyway

Patient: yeah

Student: that’s normal for anyone

Patient: right

Student: to drink

Patient: do tea and coffee included in that or

Student: uh tea and coffee are included but what w-
what uh ummm (1.5) urr i’m afraid i won’t
be able to go through all the all the
treatment options but er (1.0) if i had
time i would have gone through all of it

Patient: mmm

Student: but because of a shortage of time

Patient: okay i’ll ask the GP

Student: yes please if that’s alright (.) so umm
you have eh been having problems are you
happy with the explanation about the
haemorrhoids

Patient: yeah i see i’m glad to know i haven’t (.)
you don’t think i’m gona have bowel cancer
at the moment anyway

Student: yeah (.) at the moment cos of their cos
they’re ( ) the consultant
would have said so (.) okay

Patient: okay

Student: thank you very much for talking to me

Patient: yeah thank you